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HEALTH COOPERATION PAPERS
QUADERNI DI COOPERAZIONE SANITARIA
CAHIERS DE COOPERATION MEDICALE

POVERTY, HEALTH & DEVELOPMENT

ASSOCIAZIONE ITALIANA AMICI DI RAOUL FOLLEREAU (AIFO)
ORGANIZZAZIONE PER LA COOPERAZIONE SANITARIA

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Foreword

Poverty can be chosen by individuals, as an internal conquest, a liberating choice. However, this book is about poverty forced on persons, who do not have any other choice. Such forced poverty is linked to injustice, pain, desperation and rebellion.

During the last decade, on one hand the percentage of persons living with less than one dollar per day has decreased from 28.3% to 24%. At the same time, the absolute numbers of the poor has remained stable if not actually increased in this period, with the increase in the world population.

About 1.2 billion persons continue to be below the limits of absolute poverty, as defined by international criteria.

If the criteria for defining poverty is increased to 2 dollars per day, the number of poor arrives to 2.8 billion persons. This means almost half of the world's population continues to live in such unacceptable conditions, that to talk about development, rights and health may seem like a provocation when the poor have difficulty in their daily survival.

In 1820, the difference of income between the rich and the "developing" countries was almost 3 to 1. By 1999, this difference had increased to 700 to 1, not withstanding all the technological and productive advances, which are supposed to improve life conditions.

These are just numbers to be quoted in different reports and we have become used to looking at such numbers.

In reality, the system developed in the rich North over the last century has produced an incredible and scandalous economic disparity.

The scandal arises from a deeply unjust planetary order, which is accepted with indifference by the prosperous communities of North, even if we insist on talking about promoting development. Our ideas about development, in reality tend to reduce the value of life to the market forces and are geared towards profit and consumption, destroying the human relationships and environment.

It is not enough to protest and to shout slogans against the multi-nationals and the aggressive super-powers, nor do we need to appeal to the good will and generosity of persons. We need a new culture, a new proposal for overcoming that sin, that Raoul Follereau called the "other leprosies" – the indifference towards the poverty and misery of others. For this new culture, we must start from our own selves. There is an allegory about anger and violence of the excluded persons exploding and waves of misery sweeping away the opulence of the "golden islands".

However, the crude reality of our times has gone beyond all allegories.

Dr. Enzo Venza
President
Italian Association Amici di Raoul Follereau (AIFO)

Introduction

The "Italian Association Amici di Raoul Follereau" (AIFO) is an international non-governmental development organisation supporting leprosy control, primary health care and community-based rehabilitation programmes in different countries of Africa, Asia and South America since 1961.

AIFO's mission is:

> *"AIFO has chosen to focus its activities in supporting leprosy affected persons and persons with disabilities through integrated development projects in a spirit of partnership, with particular attention towards the poorest and vulnerable groups of persons.*
>
> *At the same time AIFO promotes activities of development education in Europe, for a better understan-ding of causes underlying poverty and under-development and for a just North-South relationship"*

Through the projects supported by it, AIFO aims to reach the poorest population groups in developing countries, for promoting sustainable development. However our experience and independent evaluations carried out in projects supported by AIFO over the past years show that it is not easy to reach the poorest and most marginalised population groups, especially for development activities. Though such groups may benefit from charitable and social welfare activities.

For understanding the reasons of this discrepancy, in October 2001 AIFO decided to organise an international workshop for project-managers from developing countries. The aim of this workshop was to discuss and understand the different dimensions of poverty and the difficulties for reaching the poorest and most vulnerable population groups through development activities.

A total of 64 participants from 16 countries participated in this workshop, which was held in Bologna (Italy) from 26 to 31 October 2001. The general format of the workshop included a daily keynote presentation by an external resource person on the general theme of the day, followed by two smaller presentations about personal experiences on that same theme by two participants. The presentations were followed by group discussions followed by plenary sessions. At the end of the workshop, a final document was prepared, which was approved by all the participants.

The **first part** of this book presents the main presentations and a summary of main discussions during this international workshop. It is very difficult to capture the dynamics of passionate discussions and debates in written documents and it is impossible to the show the essence of solidarity, participation and friendships, which characterised this workshop with persons

speaking in English, French, Italian and Portuguese. Our sincere thanks to all the participants and external resource persons for their passionate participation in this workshop.

The **second part** of this book presents the report of a pilot project, carried out jointly by the Disability and Rehabilitation team of World Health Organisation (WHO/DAR) and AIFO for promotion of **community-based rehabilitation in urban and suburban slums** and low-income communities. This project has been a significant effort in reaching the marginalised groups of disabled persons, especially disabled children in urban settings and links very well with the theme of this book. This project showed that community-based development strategies are possible and needed even among the most marginalised groups, living in urban slums and low-income areas.

Finally in the **third and last part** of this book, some other articles on the same theme of "Poverty, Health and Development", written by contributors from different parts of the world have also been added, including some papers presented during recent national conferences of AIFO.

Many of these contributions come from persons involved in **People's Health Movement (PHM)**, an international movement of voluntary organisations and health activists from different parts of the world, fighting for "Health For All" as a Human Right and asking for equity and justice for all people of the world. AIFO is deeply committed to PHM.

Given the different origins of the articles included in this book, the styles of writing are very heterogeneous, ranging from personal experiences to proper academic papers. Hopefully, this will result in a stimulating and provocative mixture. Often, these discussions about poverty and strategies for promoting participatory development lead to discussions about some aspects of globalisation, showing the links between micro-level activities and macro-level policies.

We do hope that the book will be useful to all those persons and organisations involved in supporting the poorest and marginalised population groups in their efforts for justice, equity and a dignified life and in understanding the difficulties in these endeavours.

Part I

Proceedings of the International Workshop on *Poverty, Health and Development*

Bologna, October 2001

Opening Address

Enzo Zecchini

Dear friends,

Warm welcome to everybody. This workshop is a very important and privileged opportunity as it involves so many representatives of various projects supported by AIFO in different continents.

Our Association has chosen to work along with the poor and marginalised persons and population groups, through interventions which aim to assert the right of each one of us to become responsible of our own life and to have the opportunities to fulfil our innate capacities. We claim the right of every human being to live in good health, peacefully and in harmony with environment, in a way, which respects the culture of each one of us. We aim to work together for a future with justice for everyone.

The theme of this workshop is "Poverty & Development". Your task during these days of the workshop is to clarify the obstacles, which prevent poor persons and marginalised groups from accessing development and to define strategies to overcome those obstacles. Your work during this workshop will be useful for definition of future strategies of work of our Association.

In addition to this specific task, this workshop is also an important opportunity to exchange experiences, to understand and learn from each other.

I am trustful that, beside helping AIFO to define our strategies for reaching the poorest population groups, this workshop will be useful to each one of you to look at your own work through the critical eyes of the others to improve it when you will go back to your own countries.

Thank you for being here with us and may you all have good work during these next days in Bologna.

Why Do We Need to Talk about Poverty & Development?

Sunil Deepak

Good morning and welcome to every one. As usually happens in such international workshops, where persons come from different corners of the world, not all of them are able to reach in time. We still have some persons who were expected to be here this morning but they haven't arrived yet. We hope that they will be able to make it soon.

Let me start with a clarification. I can imagine that some of you are saying to yourself that this is another of those meetings about poor persons and poverty, where we sit in a luxurious hotel and talk about far away places and far away persons. I have also been to some such meetings and I know the feeling. As you can see, the hotel for this workshop is very nice. While looking for a venue for organising this meeting, we really had to search very hard as we needed a place, which was accessible to wheel chairs and disabled persons. In Bologna city the prices for such a place were too high for us. Finally, we found this place, a little isolated, lost in the rural periphery of Bologna where they have the facilities to accommodate disabled persons and where, the management, once they heard about the kind of persons who were coming here and our subject of discussion, agreed to offer us a very special price for boarding, lodging and meeting rooms. This is the reason, why we are here and I shall like to take this opportunity to thank the management of this hotel for their collaboration.

Another small point I would like to make is about the participants for this workshop. There are very few participants from Africa present here and we sincerely regret that. However, for one reason or the other, many of the persons from Africa, who were invited to this workshop were unable to come.

On the other hand, we do have very large representations from India and Brazil, the two countries where AIFO is involved in many projects with a number of different partners and where we have our regional offices. This will create a challenge for your informal sharing of experiences and knowing each other because of linguistic barriers. All the formal plenary sessions have simultaneous translation in English, Portuguese and Italian. For group discussions, the groups have been divided on the basis of language. I do hope that you will make your efforts to take advantage of those persons who can speak both English and Portuguese, to get to know each other.

AIFO's interest in poverty related issues:
Now coming to more specific issues related to this workshop. Why did we decide to organise this workshop on the subject of poverty and development? As many of you know, in 1961 AIFO started as an organisation for working with leprosy affected persons. Right from the beginning the founders of AIFO felt that leprosy disease is closely linked to poverty, injustice, exclusion and underdevelopment. Thus the motto of work chosen by our founders was "Against Leprosy and Against Other

Leprosies", where "other leprosies" includes issues like poverty, exclusion, under-development, etc., which create the conditions so that diseases like leprosy can exist.

This philosophy also meant that our work for fighting leprosy has to be extended to developed countries, even if there are no persons affected by leprosy because the conditions of poverty and under-development in the South depend also upon the past colonial history of developing world and the continuing imbalances and exploitation relationships that exist between the North and the South of the world. For this reason, apart from supporting health care, rehabilitation, research and development activities in different parts of Asia, Africa and South America, AIFO groups are also involved in activities of development education in Italy, promoting a change of mentality, to create awareness in general public about issues of injustice about existing world economic order, about importance of cultural diversity, about sustainable development, about human rights, etc.

Impact of AIFO's work on the poor: It has been quite some time that we have been asking our selves, "Do projects supported or managed by AIFO, reach the poorest & most marginalised population groups?" I do not think that there are any development NGOs, who do not wish to focus their work on the poorest and excluded population groups. Yet can we take it for granted that the projects and the programmes we support are e ffectively reaching the poorest groups for promoting sustainable development?

Over the last decade, there have been different occasions when we have tried to look into this question through evaluation of community-based and primary health care programmes. In 1999, an evaluation carried in South Sulawezi in Indonesia, focused on the impact of the community-based rehabilitation (CBR) project supported by AIFO on the lives of poor groups living in the urban slums in the city of Ujung Pandang. In Mongolia, another evaluation of a CBR programme focused its analysis on benefits to the poorest groups through the rotating credit for income generation activities. There have been many other such evaluations and the end result has been almost the same every where - often the poorest population groups and most vulnerable persons *do not* benefit from development activities but are involved in mainly social-welfare or charitable kind of activities.

In 1998, in another international workshop organised by AIFO, Dr Peter Evans from had presented the preliminary results of a multi-centric study carried out in different parts of India with support from DFID, in which a team of researchers had looked at the accessibility of different kinds of services to disabled persons from the poorest population groups. This study analysed the accessibility of governmental institutions, charitable and missionary institutions and community-based rehabilitation programmes. The results of this study indicated that the issue of accessibility of services to the poorest groups is complex and in spite of providing free services in an institution, these can still remain inaccessible to many vulnerable groups. He also found that community-based services were more accessible to the poorest groups, though most of the poor groups were not aware about the activities carried out by NGOs.
Over the last six years, AIFO has been involved in a joint initiative with Disability & Rehabilitation team of WHO (WHO/DAR) called "Promoting CBR among vulnerable

population groups". This initiative is trying to look at the feasibility of promoting CBR programmes in two specific vulnerable population groups – the slum dwellers and the refugees, through a series of pilot projects in different parts of the world. From this initiative, it comes out that involving the poorest population groups in development is not easy but it is possible. The same lesson comes from some other community-based projects like WATCH in Nepal, working for empowerment of rural women through participatory development methodologies.

Some of the reasons coming from these different experiences for explaining the exclusion of the poorest population groups from development activities include – their lack of prerequisites for participation in project activities, their lack of education and skills, their lack of awareness about their rights and the availability of services, their lack of self-confidence, etc. At the same time, they are excluded because of barriers created by more powerful groups in the communities and societies because of religious, ethnic, linguistic, racial or caste differences.

Aims of the workshop: The aim of this workshop is to be together, coming from different countries, cultures, contexts with your experiences of working along with the poorest population groups, and to reflect together on how we can reach the most marginalised groups in our work.

Over the next four days, there will be different keynote presentations to provoke you and to stimulate you, followed by group discussions and then plenary sessions during which the groups will share their discussions. At the end of the workshop, I hope that each of us will be able to look at our own work and reflect on ways to improve it so that it responds better to needs of poorest groups. There are three main themes for this workshop:

Defining Poverty & Criteria
Equity & Access to services
Listening to & Understanding the Voices of Poor

I shall like to take this opportunity to thank all those who have accepted to present the keynote presentations for this workshop and all the participants, coming from near and far. ■

Poverty & Development – The Global Context

Mira Shiva

I shall be speaking about the present global context so that discussion about the situation of poor is seen against this background. I am going to start with the meaning of development, what has been done in the name of development, and how exploitation has taken place in the name of development.

What do we mean by Development?

Does it mean Progress, well-being, better living standards of the disadvantaged populations, social security, meeting of the basic needs of all,

Or

Does it mean Modernisation, western paradigm of economic growth, used by First World interests to reshape politics, economies, of poor countries of poor countries?

When we talk about development we imagine, we think and we believe that we are talking about progress, we are talking about well being, we are talking about better living standards of the disadvantaged populations. We are talking not just about people who are in remote areas and from poorer countries, but also in more specific terms of women, disabled persons, elderly persons and the minorities. When we are talk about development, we imagine that people should have social security and their basic needs should be met.

Unfortunately the major development paradigm emerging from the rich countries, which is guiding a lot of the work in development and other sectors, is about increasing profits and economic growth. This is the western paradigm of development and it is reshaping the politics and economies of the poorer countries. It tends to be manipulative, and this is what we are calling the new colonialism (**neo colonialism**). This is the economic growth-oriented model of development.

Growth Oriented Development

It perpetuates **domination of the North**, imposed on the South and is synonymous with econo-mic growth. It's goal is to improve poor country's **market potential** by increasing Gross National Product and so economic growth is pursued through industrialisation, agribusiness & trade.

However, there is another model of development - the equity oriented development.

Equity Oriented Development

It places **basic needs of people before** predatory pursuit of economic growth. It recognises that health, well being, security of people depend upon **fair** distribution of resources and power. It involves **People's participation**, involving as many persons as possible, in decision-making about their lives

Equity-oriented growth is also related to the questions of sustainability, participation and democratic norms. For this paradigm of development we need to talk about economic equity, and also about social equity and gender equity.

Among these two development paradigms, it is the economic growth model that is dominating the entire international policy-making and the national policy-making. It's influence is not limited only on governmental and international policies and pro-grammes but it is also influencing the development philosophies of many non-governmental organisations. Why did this happen? To understand this, we need to look at the genesis of globalisation and the debt trap.

Genesis of Globalisation
The Debt Trap

- Post world war II (1945 - 1970) - golden age of capitalism
- Nov 1973 – Hike in oil prices by OPEC – Profits deposited in banks in rich countries
- Illicit incomes of Third World dictators also put in western banks
- Money from drug smuggling also put in western banks
- Banks with surplus money – "easy" loans to developing countries in late seventies
- Loans given easily but with conditions for loans repayment
- Rise in interest rates, devaluation of currencies so now more and more amounts are spent by loan-receiving countries for servicing these debts
- Newly independent countries have been economically re-colonised
- A sharp decline in commodities exported by developing countries
- Increasing imports from developed countries, worsening economic crisis

Understanding the genesis of globalisation and debt trap is important to understand how globalisation process influences our work and why so many countries are in increasing debt. To understand, it is important to go back and look at the history.
In the post World War II, there was the golden age of capitalism. Many of the international financial institutions were set-up after World War II, like International Monetary Fund (IMF), World Bank and Global Agreement on Trades & Tariffs (GATT). The UN system was also set-up during the same period.

There were some big changes in November 1973 when the oil prices were raised by OPEC, resulting in huge profits for some oil-producing governments. These profits were put in the western banks in North America and Europe. These banks also received funds from the illicit incomes of the third world dictators. In Philippines, in Panama, in some other countries across the world, the dictators were supported by those western governments, who love to talk about democracy, liberty and freedom. Money from drugs smuggling, arms-trade, and similar activities was collected in the Swiss Banks and western banks.
These banks had surplus of deposit money, which was used for the loans offered to the developing countries at very low interest rates. This was also in the interest of developed countries because they realised that to make more profits, they needed more markets as the markets in the western world were not enough.
So big loans were given easily to the developing countries for big projects with

little verification. Many of those projects were mega projects, which were top-down, without any local participation, without any consideration about the local social and cultural contexts. Most of this money given irresponsibly by western banks was thus wasted.

In eighties, the interest rates for these loans were suddenly increased. So now, those countries were asked to pay back huge amounts as interests, calculated all in foreign currency like US dollars, while their local currency were devalued. Considering the huge amounts of interests paid on the loans, many countries have already repaid many times the original amounts that they had received. This is the debt trap. In spite of all the money that has been repaid, the original capital remains untouched. Normally, banks are responsible for any bad loans they give but in this case, these loans have been taken over by the western governments, which continue to put pressure on poor countries for repayment. The western governments and institutions like IMF are bailing out their banks by giving more loans to poorer countries for payment of interests and are forcing new conditions on the governments of indebted countries asking them to cut social sector spending, etc. These are the structural readjustment programmes.

The newly independent countries of the South, were supposed to be independent, but are actually economically re-colonised. There is a sharp decline in commodity exports from the developing countries. If you look at the prices of coffee, rubber, pepper, coconut, etc. - all these commodity prices have surprisingly gone down over the last decades.

At the same time, imports from developed countries are increasing. These have been achieved through forced imports-liberalisation as part of structural readjustment programmes. The debt trap is being used by western countries to open the local markets of poor countries, to the products from industrialised countries. Poor countries are forced to import non-essential products and luxury goods, which leads to the further worsening of their economic situation. Thus precious foreign exchange wasted on import of non-essential goods and local industry is killed systematically.

The Financial Dimension of Globalisation

Flow of finances from South to North: in 1985, it was 50 Billion US Dollars; in 1990, it increased to 156 Billion US Dollars

Trans-national corporations mergers: Creating bigger and stronger Trans-national corporations. In 1996 – there were mergers for 0.9 Trillion USD; In 1999 – there were mergers for 3.4 Trillion USD

Globalisation has a financial dimension. Increasing net flow of resources from the developing South to the developed North and the increasing mergers of trans-national corporations are two sides of this financial dimension of globalisation. This explains how the exploitative system creates increasing poverty in which, institutions like IMF are used to further the hegemony of developed world.

To illustrate the active role played by Western governments in this process of impoverishment of the poor countries, it is useful to listen to a speech made by Mr. Lawrence Summers at a bankers' meeting. He had worked with World Bank and at the

time of this speech worked for the USA Government. He said, "Since we're enjoying influence of the international financial institutions (World Bank and IMF), which support our values and policy goals. They provide a powerful way for us to leverage resources." He gave an example about India saying that this support in India has forced a revolution in economic policy and has reduced their tax rate from 87% to 27%, which is more reduction than what is asked in GATT (General Agreement on Tariffs and Trade).

By forcing developing countries to reduce the tariffs and import duties, their income from these import duties is reduced and there are more profits for the trans-national corporations. On the other hand, the governments of these countries are looking at other possibilities for their revenue. For example, in India many state governments are setting up liquors shops for collecting revenue, while food and essential items are taxed and public-spending is drastically cut. The power of the international financial institutions is very strong as they have uncontrolled decision-making powers about the third world debt.

Since 1947, World Bank has made lot of profit. It has never gone into a loss. At the same time the international financial institutions are considered as "development agencies". About 44% of the decision-making control of the World Bank is with only 5 countries - USA, UK, Germany, France and Japan. Some decision-making countries definitely benefit from these agencies. The multinational corporations play a major role in influencing them.

All the local level decisions depend upon decision-making by the national governments and even if these are democratically elected governments, we can imagine the kind of health policies, economic policies and agricultural policies these governments can promote under the pressure of the international financial institutions through the Structural Adjustment Programmes (SAPS).

Common Features of Structural Adjustment Programmes (SAPS)

- Economic policies are imposed on Third World countries by IMF & World Bank to ensure that servicing of debts and interests takes place, irrespective of their devastating impact on the poor
- They are asked to cut government spending for "non-productive" services like health care, education, food subsidies, etc.
- They are asked to privatise state owned industries & services like transport, power, health care, education, etc.
- They are asked to devalue local currency for increasing exports, paying back interests and loans
- Farmers & local industry get less resources and import prices go up; farmers are asked to shift to cash crops for export
- Countries must open up to foreign multinational corporations like – Enron, Coca cola, Nike, KFC, Cargill, Monsanto, Shell, Dupont, Pizza Hut
- Countries are asked to reduce duties and tariffs on imports - import liberalisation; killing local industry, provide markets to multinational products

The SAPS are something about which, people in Latin America and Africa have experienced long before we in Asia came to know about it. For us the new economic policies of the Structural Adjustment Programmes came up only in the nineties - in India in 1991.

Through SAPS, the economic policies are imposed by IMF and World Bank to "adjust" the economic structures of poor countries, to ensure that they can continue to pay the interest for their debt and have a devastating impact on the poor. These policies include measures like cuts in the social spending, cuts for activities linked to education, health, social services for elderly persons, disabled persons, persons needing shelter, for housing for the poor, etc. These also include removing of the subsidies, like food subsidies for the poor, which are essential for the survival of the people living below the poverty line.

There are countries where 60% of the population lives below the poverty line. Even in countries like India, between 26 to 40% of persons are below the poverty line. Feminisation of poverty has taken place and large number of poor are women. Poor also include the "low caste" and tribal persons. They include people living along the coastal areas of India, who are the traditional fishermen and who are no longer able to fish.

The numbers of persons living below the poverty line is on the increase. So much so that the **World Health Organisation (WHO)** has created a new category for **extreme poverty** in the International Classification of Diseases called "Z 59.5". WHO in its World Health Report recognises that the disparities are increasing, that extreme poverty is increasing worldwide, and because of that, all the diseases of poverty are increasing. Human development report which, measures poverty and well being through human development indexes, confirms this finding.

SAPS ask for removal of price controls by the national governments including for essential items and medicines.
These controls ensure that producers do not make excessive profits and that poor persons can afford these essential items and medicines.

Deregulation, liberalisation and privatisation are key pillars of SAPS and are closely linked with globalisation. All state managed services and industries like transport, power, health care, education, must all be privatised. So in reality, SAPS mean that any concerns about the poor people have no place in the policy making – such concerns must be left only to the private ownership!

SAPS ask for the devaluation of the local currency for increasing exports. It means devaluation of the labour. So when you have to buy essential items from other countries and pay for it in US dollars, it costs more and your own products cost less. The financial experts say that devaluation of currencies will make you more competitive. It will be good for your exports and then you can earn more foreign exchange, etc. These are just illusions to sell their ideas and products.

There has been a shift to cash crops for export, so farmers instead of producing food, have moved into cash crops like growing flowers, growing cotton, etc. They using more pesticides while farming is capital intensive. At the same time, increasingly seeds are coming under the control of the multinationals.

Impact of SAPS on Health Sector

- Cuts in health sector budget – dismantling of public health services
- Introduction of user charges for basic health services
- Handing over health services to private sector – maximising profits, attention on curative medicine
- Vertical health programs funded by World Bank loans are being promoted
- Voluntary sector is forced to concentrate on internationally prioritised & funded health interventions

SAPS have a clear impact on health services. The cuts in the health sector budgets and the dismantling of public health is taking place across the world. Public health is being replaced by pharmaceutical-based curative care. The private sector is not interested in providing public health because public health does not provide profits while the curative care is profitable. Giving importance to curative care means emphasising the **biomedical model** of medical care. This means that you look for technological fixes for every health problem.

However, **complex health issues** cannot be addressed by simple technological fixes. Air pollution can not be solved only by face-masks. In the same way, the causes of HIV-AIDS and sexually transmitted diseases are more complex and can not be solved by only condoms. Families in the rural areas, they migrate to cities to look for work for survival. For them, the conditions of sickness and malnutrition are increasing. Poor women are forced into prostitution for survival. Thus the real causes and determinants of illness and ill-health are ignored systematically and there is limited focus on finding technological solutions by reducing the issues to the bio-medical context.

The **vertical programs** based on the World Bank loans have all "magic bullet" solutions for every thing. For tuberculosis (TB) the programme is based on DOTs, for malaria they focus on impregnated bed-nets, etc. No one can say that TB, malaria, HIV should not get a priority, but the control of these diseases has to be comprehensive. It has to ensure optimisation of resources and it has to look at possible role of other **traditional healing systems**. Instead, they work for systematic asphyxiation of all other systems of medicines with a pathological zeal.

This is the direction taken by international health-policy making. The national policy making is also in this direction, promoting vertical programs with the help of international loans. So they are asking for introduction of user charges, which is already happening in many countries. If people have no money to eat, how are they going to be able to buy health care? This is why infant mortality rates and maternal mortality rates are increasing once again. World Bank has emerged as the largest international player in health services promoting the vertical health programmes while the role of WHO has been completely and systematically marginalised.

World Trade Organisation's (WTO's) Trade related intellectual property rights agreement (**TRIPs**), is also part of the globalisation. Since knowledge has become a property of those who can control the world markets while property rights of people and collectives are forgotten, it has a serious impact on the indigenous knowledge. To

explain this, I can tell you the story of '*Neem*' tree. Its scientific name 'Azadirachtin' is derived from *Azad Darakhte Hind* (the Free Tree of India) and is very common in India. It has bio-pesticide properties.
The leaves of this tree are put in the woollen clothes to safeguard them from insects. You can crush the same leaves and use it for treating scabies and some other skin infections.
It is something that has been used in Indian homes for thousands of years, and it's description is written in our traditional text books of *Ayruveda* medicine. It has been patented in USA. If something like this can be patented, what is the level of **biopiracy** going on the world for other lesser-known traditional knowledge? The voluntary organisa-tion sector in our countries has been forced to concentrate on international priorities and vertical health interventions because funds are available only for these. And this is a tragedy because it means ignoring much wider concerns of public health. Look at the large number of organisations working on AIDS. Again I am not saying that AIDS is not a concern but can you separate it from the question of reproductive health? Can reproductive health of women be limited mainly to a question of contraceptives?

If they are concerned about HIV and population control, why are they cutting down the budgets for health services and primary education? Education of the mothers is closely linked to the health of the families. Many studies have clearly shown that whenever a mother has some education, it has a positive impact on the infant mortality and maternal mortality rates, especially when women have access to some resources.

Impact of SAPS on the Poor

- Increasing loss of livelihoods leading to increasing poverty
- Loss of women's livelihoods leading to increasing poverty
- Increased prostitution and trafficking of women – leading to increasing HIV/AIDS
- There is resurgence of diseases like tuberculosis and increase in sexual violence and exploitation
- The drugs cost are increasing
- There is increasing Toxic trade leading to increasing chemicals in body & environment

With this model of globalisation, **lifestyle diseases** are increasing. Alcoholic drinks, tobacco and smoking are being promoted. Any attempt to regulate the advertising for such products is considered as "interference with trade". National budgets are made in a way that the prices of music systems, computers, TVs, washing machines, etc. are decreasing but those of rice, wheat and cooking oil are increasing, affecting mainly the poor.

Till now the large corporations have been concentrating on their profits from sales of luxury goods like cosmetics and alcoholic drinks but now they are planning to enter **the "market" of basic needs** like food and water. The market of basic needs is much bigger and will exist forever. So big corporations are entering the food sector and they are asking for privatisation of water supply. When a large number of people can not afford minimum basic health care and the 80% of all health problems among the poor are water and food related diseases,

what is going to happen to those poor? What will happen when the large corporations will control the supply of water? These are some of the things about which, we had never thought about before. We could never imagine that our rivers and the lakes, our forests and the villages be the next targets of the multinational corporations. Now if the tribal persons take some wood from the forests, they are blamed for deforestation. They talk about each poor person cutting so many trees from the forest, but they do not talk about big corporations who have the contracts to cut and sell hundreds of thousand of trees from those same forests. For producing disposable chopsticks and for producing toilet paper how many of the Indonesian trees have been cut?

These changes have put enormous strain on the social fabric and traditional lives. Ethnic **violence** and communal violence, along with **violence against women** are all increasing. The impact is especially grave on the women. In 1995 the Women and Child Development report said that one third of the households in India are women headed. So if you see increase in prostitution and trafficking of women and minors, this problem is not confined only to India, Nepal and Bangladesh, but it extends to whole of South East Asia. At the same time, in India clinics for pre-natal sex determination are flourishing along with female feticide and infanticide. People who do not have economic value have no reason to exist and thus women are increasingly seen as a liability. Their labour in the home has no value in terms of money for the economists, because for them work has a value only if you sell your services. So in the last national census in India in 2001, female to male ratio shows a dramatic fall in 0-6 years age group.

There is an **increase in drug costs** over the last years. For some drugs the prices have increased 100% while for some others, increases of even 200% have taken place. The recent examples of drug companies pressurising poor countries as in South Africa and Brazil show the risks.

The trade in toxins and chemicals, along with the "chemicalisation" of the body and environment are on the increase. Toxic dumping is an established practice. As the Northern countries are becoming more environmentally aware, much of the toxic waste is passed on to the South and the **trade in toxic waste** is increasing.

The **disparities** between the rich and the poor countries are increasing. In 1960, 70% of the poor received 20% of the global income, in 1990 they got only 1.3% of the global income. Over 60% in developing countries do not have sanitation and hygiene services. More than one third do not get drinkable water. One fourth do not have shelter and one fifth do not even finish the primary education. One third of new-borns in developing countries are low weight babies, 52% of under-five children are malnourished and 55% of pregnant women are anaemic. I believe that when food is going to be seen not as nutrition-provider but as a commodity for making profits, the entire situation of food security for the poor is going to get worse.

Fighting Diseases in the Developing World?

- Between 1975 & 1996, 1223 new drug molecules were developed – only 11 of these are for treating tropical diseases
- Last major new anti-tuberculosis drug was 30 years ago

- Drugs for diseases of poverty are not developed for lack of market & profit

Fighting diseases in developing world is increasingly more difficult. Drugs for diseases of poverty are not developed for lack of market and lack of profits. The big pharmaceutical companies are interested in developing new drugs like Viagra, appetite stimulants, mood elevators, weight-losing drugs, etc. as these earn more profits.

TRIPS has provisions like compulsory licensing, which allows other countries to produce their own drugs in case of grave public health needs, but industrialised countries and drug companies do not want to allow such possibilities. When South Africa wanted to make anti-retrovirus drugs for AIDS, 39 companies took them to court. Had it not been a global campaign by the health activists and drug activists, those drug companies would not have withdrawn the case. They were forced to comply because their image was damaged due to campaigns by health movements and people's movements.

Rise of People's Movements To Counteract These Changes

- They have an Advocacy role – to inform and to interpret the information in favour of the poor
- They have a Training role – by equipping trainers, communities, social activists with knowledge & capacity to fight oppression
- They have a Networking role – to develop a critical mass to fight for social justice

As can be seen from this very broad overview of different issues in the global context, the role of people's movements is very crucial. As People's movements, we have to play an advocacy role, to analyse how the proposed changes are going to affect the poor and create awareness about the adverse effects of the changes connected with globalisation.
People's movements for health also have an important training role and they need to network with all other movements linked to development and other issues. **People's Health Assembly** and **People's Charter of Health** are examples of this role of People's Movements.

Finally let me finish this presentation about the global context in which, we need to look at poverty with a comment on the importance of **non-governmental organisations**. NGOs must refuse to accept unjust laws and policies and network with each other and people's movements to create awareness and pressure against such policies. They must challenge the common thinking "There Is No Alternative" or the TINA syndrome. Alternatives are there and the economic development paradigm proposed by international financial institutions must be challenged. We have to be particularly aware of the impact of policies on the lives of the poor, marginalised population groups, especially women. Support those that are equity oriented and resist those that deny people their rights to live with dignity. Thank you. ■

Voices of Participants

Lemuel S. Boah, Liberia
Government and donor agencies must initiate the process of economically empowering the community/poor, and leave the continuity for the empowerment and development of their lives with the community/poor.

J. Alexander, India
Globalisation as part of the new economic order has come to stay in the world. Those of us who work with the poor should make use of all the resources at our command, namely media, organisations of people etc., to bring to the notice of policy makers, that, while we work for alleviation of poverty and for the reduction of the sufferings of the poor, we should not lose sight of the negative impact of globalisation and market-economy which causes many people losing their employment and income.

Eloisa Manzano, Brazil
It is important that all organisations and networks involved in working for the poorer and weaker sections of community can share and join together.

Saverio Grillone, Comores Islands
Unfortunately, some representatives of World Bank and International Monetary Fund have played a very negative role in Comores, when they came to speak with the authorities of our country. They have insisted on structural readjustment programmes, which have made the already bad situation, even worse. As they have blackmailing attitude with our Government, they have forced degradation of so many problems. Political instability and lack of Government leaders with clear ideas have helped in this degradation. They have forced rigid ideas and conflicts with NGOs working for poor groups. We are blamed for giving assistance to the poor and to block their development, as we oppose the fee for service for accessing health system, for the poorest groups. Health system has been especially penalised by these policies of IMF and World Bank. Our health budget has been cut. Earlier, the contribution of the Government to the health system was low, but this has been further cut following directives from World Bank and IMF. They talk about community participation for covering the cost of basic services. But even if the poorest are forced to pay a fee, this can not be enough to cover all the costs of running a health service, unless the Government provides proper budget for it. So now our hospitals do not function and every thing must be paid for, consultation, drugs, every thing. How can poor persons go to the hospitals in such conditions?

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Poverty & Identifying the Poor

Usha S. Nayar

CEU-SUCHARA

For this presentation, I have tried to conceptualise the basic ideas about poverty and to classify these ideas into some categories. This presentation will also look at the criteria for identifying the poor when we wish to work with poverty groups.

At the threshold of the next millennium, cities throughout the world face formidable challenges to deal with a spate of urban pathologies, problems of survival, crime, delinquencies, violence, unemployment and environmental degradation. (Sengupta, 2000). Poverty, whether rural or urban, therefore needs to be looked at from a range of perspectives. Poor women, men and children experience poverty in their daily lives. It affects where they live, what they eat, how they spend their days, and above all, their general well being. It is a multi–faceted issue. Within the general condition of poverty itself, for instance, individuals experience poverty differently according to their gender, age, caste, class and ethnicity. Income levels and food security are invariably influenced by these factors. (Susan Loughhead, Onkar Mittal, 2000)

Poverty is not of just one type, one homogenous group of persons. It is also linked with various types and various degrees of deprivations.

Types of Poverty

- Inherited Poverty
- Instant Poverty
- Temporary Poverty
- New Poverty

- Relative Poverty
- Hidden Poverty
- Endemic Poverty
- Overcrowding Poverty
- Terminal Poverty
- Absolute Poverty

While analysing different kinds of Poverty, **Inherited Poverty**, would refer to a situation, when poor parents have poor children, who grow up to be poor parents and this cycle goes on and for generations people remain poor.

Then there is **Instant Poverty**, which is caused by some crisis or disaster, and it could be for a very short time. For example, it could be because of lack of rains or because of too much rain, and for some persons it can be a temporary event. Once the main crisis passes, gradually the family can rise above the deep poverty level.

Temporary Poverty, there could be also another type of poverty which is also temporary, like the poverty due to War. The situation of the poor persons during the war can change over short periods of time.

The **New Poverty** is related to people living close to the edge. They are not really poor but can become due to changes in the circumstances like the persons who retire from work or when sudden inflation and crashing of financial markets eat away the value of salaries of persons.
These persons become poor in a new way, they were all right before those precipitating

events and now with some outside changes they have become poor.

Another concept is that of **Relative Poverty**. This is a very fashionable concept particularly when well-off persons from middle class and upper middle class, they want to laugh at our work with the poor population groups. They say that they are also poor because they cannot afford to have every thing that they would like to have. For example, the persons who are relatively poor would have shelter, they have food, and their basics needs are fulfilled, but they cannot afford to have for their children a particular type of high-costing education. So this relativity concept has to be understood and should be communicated to better-off persons, who would like to benefit from your work.

The concept of **Hidden Poverty** is related to persons living in far-away, very remote conditions. No one knows about them. They are deprived but the organisations and persons working with poor groups do not know about them.

There can be **Endemic Poverty**, in terms of spread of poverty over a geographical area. Low productivity and poor base of resources in the area may cause it. For example, in the same country, there can be variations in the situation of poor population groups in different areas. In cities, there can be groups of displaced workers coming from rural areas, who can be very poor. This concept is very similar to **Overcrowding Poverty**, when a large numbers of persons are forced to live in small and overcrowded areas. In such situations, persons may have no choice but to force themselves to share shelters, share food, share everything.

Terminal Poverty relates to those population groups who have been poor from the beginning of their life and they will be poor till the end of their life too, so that there is no change in their condition during their lifetime. Usually, you see some changes in the lives of persons, some times for better and some times for worse, but for terminal poverty, the condition always remains bad. Finally, let me talk about the concept of **Absolute Poverty**.

Absolute Poverty as defined by Robert McNamara in the Oxfam Poverty Report

A condition of life so limited by malnutrition, illiteracy, disease, squalid surroundings, high infant mortality, and low life expectancy *as to be beneath any reasonable definition of human decency*.

For the sociological point of view, where the population is more, you are likely to see more absolute poverty. United Nations has also explained this. It is a condition of life, which is limited by malnutrition, illiteracy, disease, high infant mortality, and low life expectancy. With all these parameters and indicators, they are always the worse off as they are living under conditions unfit for human decency.

Economic Dimension of Poverty

Gross National Product (GNP) as a measure of poverty – This means using Average National Income measured in US Dollars as a Criteria for Defining Poverty. With this definition countries are divided into Developed Countries, Developing Countries and Least Developed Countries
It does NOT keep into account the Local Cost of Living

The economic dimension of poverty can be measured through **Gross National Product (GNP)** by looking at national average income, which is measured in US dollars to facilitate comparison between countries. On the basis of GNP, the whole world is divided into developed countries, developing countries and least developed countries. But there can be other ways of looking at our countries and our resources. For example, once I was at an international consultation meeting about adolescent health groups and a social scientist from UK while speaking to our group, said that "Usha is from a strong and developed country, India". He said this because we were discussing the cultural context of adolescent health. But economically I come from a developing country. So how interesting is that all other dimensions like the cultural dimension get neglected while the economic viewpoint of looking at issues predominates? How can you look at the income of a population measured only in US dollars and call them poor, without keeping into account the local cost of living?

Quality of Life Index

This is another instrument for measuring poverty, developed by United Nations Development Program (UNDP). It considers a variety of factors like life expectancy, number of hospitals, doctors, nurses, schools, pollution levels, etc. for defining poverty. So it is a better instrument to consider poverty at country levels.

Quality of Life Index is another way to look at definition of poverty at international level. This Index has been defined by UNDP and it considers a variety of factors like life expectancy, number of hospitals in a particular area or district, number of qualified doctors, nurses, schools, the level of pollution in a particular area, etc. By looking at all these different factors a comprehensive picture of the quality of life of persons is calculated, to define the level of development of different countries and the level of poverty between them.

In every society, the poor lives are shorter and less healthy than those, who are better off. The insecurity and vulnerability behind this grim reality has many causes. War and civil conflict destroy the livelihoods of unprecedented numbers of people, creating vast flows of refugees. Employment is increasingly insecure in many countries and wages have fallen. State provision of health care, education, clean water and sanitation is restricted, exposing poor people to health risks, reducing their productivity and opportunities. Geographical isolation cuts people off from social welfare provision, markets and sources of information. More people are living in ecologically fragile areas, where they are exposed to risks of flooding and soil erosion. Structures of social 'inferiority' related to caste, race and ethnicity coupled with lack of control over resources, increase the vulnerability of the poor. Underlying all these disadvantages is the denial of rights suffered by women who experience systematic social and economic discrimination from the cradle to the grave. (Watkins, 1995)

North-South Dimension of Poverty and Chains of Exploitation

- North is rich and represents the developed world and South is poor, representing the developing and least developed countries.

- The rich North needs collaboration of partners in poor countries for exploitation
- There can be local North and South inside each country, among each population

Now let me talk about North-South dimension of poverty. It means that persons based in any country in the north of the world represent the rich while persons living in the south of the world are in poor countries. Now this is another way of looking at developed, developing and least developing countries. Here we have to remember what Mahatma Gandhi had said: "There is enough in the world to look after the needs of everyone but there is not enough to look after the greed of anyone." So if we take north and south of the world together, there is enough for everyone and we need not discuss about the poverty today. The North and South dimension is there, not just between the countries, but also inside each country there are north and south, each with different level of prosperity and poverty.

There can be no greater indictment of our world than the fact that one in four of its inhabitants is consigned to poverty. This represents a **denial of rights** and wastage of human potential on a massive scale. If the present pattern of development is allowed to continue unchallenged, the future is a frightening prospect, of a world with deep divisions, of societies segregated between the 'haves' and the 'have-nots', between those with skills and opportunities, jobs and wealth, and those with nothing, between those who 'count' in economic, social and political terms and those who do not. This is a prescription for deepening instability. The global poverty profile is slowly changing and taking on a more urban face. In many countries, rapid population growth, agricultural modernisation and inequalities in land ownership are resulting in an increase in landlessness among the rural poor and an accelerating their drift to urban centres.

As urban populations increase so does the extent of urban poverty. If poverty was an infectious disease, which could be caught by the rich as well as the poor, it would have been eradicated long ago. Apart from being socially unjust, high levels of inequality and widespread poverty are a source of economic inefficiency since they waste human potential.

Wider distribution of productive assets, secure and equitable forms of employment, and an end to discriminatory measures which benefit a small, wealthy elite but consign large numbers of people to poverty, excluding them from a share in the prosperity they have helped to create are all important elements of strategies to end poverty. Economic growth is imperative if poverty is to be reduced, but the distribution of wealth is as important as its creation. At an international level there is gross maldistribution of resources, where world trade and finance bodies support an increasing concentration of wealth in the industrialised world. Developments within countries have mirrored the trends in the international economy with the poorest sections of society becoming increasingly marginalised. In most developing countries, on an average the poorest fifth of the population share between them little more than 5 percent of national income, while the wealthiest fifth claim over 50%. (Watkins, 1995).

Linked to the North-South dimension of poverty are the **chains of exploitation** at

various levels. It can be at a very macro level like the North exploiting South. It can be also within the country when the more powerful and rich persons exploit the poor, when persons of higher caste exploit the lower caste groups, when the more skilled persons exploit the non-skilled persons, when the educated persons exploit the less educated or non-educated persons. There is also a gender dimension of the chains of exploitation when men exploit the women. Sometimes, women can also exploit men, but it is not done in a systematic way like it happens to women exploited by men.

Elements of the **poverty trap** include unequal rights to land and other productive resources, inadequate provision of health care and education, and the inability of the poorest to influence decisions affecting their lives. Corrupt and unaccountable governments' misplaced public–spending priorities and development policies, which marginalise poor people in the name of economic progress are all a part of the picture. Once again, the various elements interact with one another. External debt repayments and low commodity prices deprive countries and communities of the resources they need to invest in production and social welfare provision, increasing their exposure to economic crisis and poverty. This lethal interaction of global forces with local structures of poverty is the basis of the poverty trap. There is a need for redistribution of land in favour of poor men and women (in areas marked by extreme inequality in access to land) and prevention of extreme concentration of land ownership. (Watkins, 1995).

Now, I shall like to briefly mention the attributes of the poverty, which means talking about what happens when a person or a group is in poverty. I am sure that you know about the attributes of poverty from your own personal experience. One very important thing happens when one is poor. It means to be **powerless**. As a poor person, you really feel helpless and what psychologists call prolonged helplessness. The helplessness becomes part of the persons. "So, what can I do? Who will listen to me? I am poor, what is my voice?" These feelings come in. The feeling of inability to influence anything, which affects one's life. It does not mean that all poor people are not aware of the opportunities in their country. Some of them are aware of the opportunities, but they feel that they are caught in a vicious cycle and they do not have the power to get out of it.

If a person is sick or a person is disabled, it is more likely that the person is poor. When a person is poor, his accessibility to assistance and services is more difficult. The persons may know that there are services but they are not accessible to them. The illness of a family member imposes huge costs on the rest of the household, either in terms of loss of income, especially if the main income earner is sick, but also from the high cost of treatment. These problems are exacerbated in countries where the medical profession oversubscribes medicines, involving patients in expensive drug therapy, along with consultation fees. In this context, as in others, poor people suffer from a lack of informed choices. (Loughhead, Mittal, 2000).

When, I was a psychology student and doing my masters degree, I saw an interesting experiment. In which, beautiful toys were kept locked in a cupboard and children were kept outside, from where they could see those toys but they did not have access to touch those toys or play with them. This experiment was used to measure the frustration of this experience. It was a very inhuman experiment, but it was

explained to us that this is how we create frustration and measure it in an experimental situation. Similarly, if you are a person with disability, you may find that some services are not there, but some services exist, which are not accessible especially if the person lives in a slum in the city or in poor rural areas. Schools may be there but not all children have access to education especially in some countries. If you are a girl child your chances of getting into schools are less. You cannot choose to be a girl or a boy, but if you are born a girl, your status is less than that of a boy. If for going to school you have to pay for your shoes and uniforms then, your chances of going to school becomes less. Sometimes children are needed in poor families to look after the younger siblings. They cannot have toys for playing, they must take care of their younger brothers or sisters. Sometimes older children need to look after their families and must work for their own survival, therefore they cannot go to schools. Thus, lack of education can be another criteria through which, one can look at the poverty.

At least 55 million working children in the world, due to their work, local conditions, poverty and various other constrains, are deprived of education, health care, play and recreation which are *sine qua non* for their physical and psychosocial development. In general, children work for their own account as paid or piece-rate wage earners, or assist an adult worker who may be a family member. There is enough evidence that many children start working at a very early age and do hazardous work for 12-15 hours a day without any holiday. (Naidu and Kapadia, 1984).

Women are subject to multiple forms of deprivation from the cradle to the grave. Throughout the world, women play a key role in household livelihood systems in productive and reproductive capacity. As producers, they provide most of the food consumed by poor households, performing more than three-quarters of agricultural labour in many countries. In addition, they manage common resources and are responsible for collecting water and firewood. Female labour also accounts for a growing proportion of employment in commercial, agriculture and industry. Despite this contribution, women face a bewildering array of social, economic, cultural and religious barriers to their equal participation in society. The consequences of these barriers in terms of lost opportunities and increased vulnerability and suffering are immeasurable.

Some indication of their destructive effect can be summarised in a few revealing statistics. For example: Out of the 130 million children not attending primary school, some 70 per cent are female. In India, boys are twice as likely to attend secondary school as girls. Out of the 960 million illiterate adults in the world, two thirds are women. In many countries, especially in Asia, malnutrition rates are higher among girls than boys. Most female labour goes undocumented and unpaid, even though it is vital to family survival and national economies, and in most cultures women have less opportunity than men to develop their capabilities. Although women produce most food, and female headed households account for the majority of rural households in many countries women lack ownership or effective control over land, water and other resources. **Children in poor households** in poor countries assume responsibilities for fetching water, minding animals and collecting fuel wood, in addition to caring for their parents when they reach adulthood. (Watkins, 1995). The child la-

bourers are subject to severe exploitation and occupational hazards. The working children miss out schooling, which affects their human development. The girl child labourers are in addition subject to risk of sexual abuse. (Naidu and Kapadia, 1984).

What kind of work do the poor get? Poor are likely to be in informal sector, working for daily wages, without any kind of protection or social security. They often work long hours for very low wages.

Poverty among the **minority groups** is another important aspect. Poor persons belonging to ethnic or religious or linguistic minorities are also vulnerable to poverty and not only to the economic poverty. A variety of historical, social, political and economic processes impose vulnerability on the powerless disadvantaged communities. And, at the core of their disadvantage and powerlessness is the absence or denial of certain basic rights. (Nayar, 1991).

The high concentration of power and privileges deriving from the combined effects of inequalities based on class, caste, and gender has made for an environment that is extremely hostile to social change and broad–based political participation. Attempts by women to claim their property rights, or by agricultural labourers to claim higher wages, or by members of the scheduled castes to resist high caste oppression have often been met with violence, rape and murder. (Dreze and Sen, 1998).

In the context of urban poverty it is the incidence of increasing participation of women in the urban informal sector that highlight the reinforcing interaction between feminisation of work and **feminisation of poverty** in urban areas. This also results in regular domestic violence due to the fact that the stepping of the women outside the home in search of employment to sustain the family leaves the husband behind at home with a sense of guilt, powerlessness which culminates into accusing their wives of infidelity and hence a cause for added domestic harassment.

Another visible trend of added poverty amongst the urban poor is poverty compounded with **disability**. In a situation where the family has a meagre income combined with problems of alcoholism, gambling, large family structure etc., the women have to bear the brunt of it all. Her odds to face life increases manifold leaving very little scope for workable solutions to meet the regular needs of the family and the challenges of disability.

An integrated view of urban poverty is linked to the concept of **vulnerability**. The concept of poverty that is generally based on fixed measures, is a static concept whereas vulnerability is a dynamic issue as it covers the multifaceted aspects of socio-economic changes. People move in and out of poverty but may be trapped into new kinds of vulnerability. Although poor people are usually among the most vulnerable, not all vulnerable people are poor. Moreover, vulnerability exists at individual, household and community level. The primary indicator of vulnerability is poverty, which results from individual's low income, insecure employment and underemployment, low wage occupation, poor health, lack of competitive skills, productive assets, education, etc. Lack of access to shelter and basic services is another indicator of relative deprivation and vulnerability. Degraded living environment in slums, squatter settlements and on pavements and the insecure tenure status of the squatters create the conditions or basis of such vulnerability. Faced with the struggle for existence, poorly housed com-munities

suffer from violence both from within and outside the community. Gender, caste, ethnic and communal factors accentuate poverty and vulnerability of the communities. Women, children, the aged and disabled, all experience multiple forms of vulnerability. Both economic and non-economic factors are at play in creating vulnerability of different dimensions.

In most cities certain occupations through which many women draw their sources of livelihood render those women most vulnerable. Sex workers are one of such vulnerable groups. The vulnerability of sex workers essentially stems from their poverty conditions. They continue to live in poverty because they are kept bound down by a set of exploitative work conditions; because they are neither free as workers, which means the process of sale of their labour is governed by factors beyond their control, nor do they have the social option of not working as a sex worker. Vulnerability refers to a condition of living that is detrimental to the psychological, physical and social well being of individuals, communities and social groups. Poverty and vulnerability in terms of loss of social, human and physical assets, social exclusion and inequality are seen to be on the increase. (Sengupta, 2000).

Another manifestation of poverty is the alarming growth in the number of **street children** into the metropolitan cities. They live and grow up on the margins of society, in a state of neglect and deprivation, often without education, without affection, care and guidance from adults. The street children live, work and struggle for survival in an environment, which is not sympathetic to them. (D'Lima Hazel etc., 1992). Acute poverty coupled with domestic violence in rural and urban households often compel the children even as young as 4- 5 years to seek refuge away from their homes by running away. Their tryst with poverty does not end here. They get entrapped into another web of poverty, which results into a life on the streets, which is compounded by sexual, physical and emotional exploitation. Left with no alternatives they are resigned to work as rag pickers, casual labourers in restaurants or resort to begging. The vulnerability of these children often makes them an easy prey for exploitation in the commercial sex markets, which is ever growing by leaps and bounds.

Another attribute of poverty is linked to **wars and armaments**, eating up disproportionate parts of the national budgets. They kill and disable whole populations and they create millions of homeless people. Naturally this worsens the poverty. Significant reductions in expenditure on the military could translate into increased public investment in socially useful and productive activities. Military spending represents a massive diversion of resources from investment in human capacity, throughout the developing world. (Watkins, 1995).

Finally, it is interesting to look at the spiritual dimension of poverty. Often the poor persons believe in faith and God and they may not give much importance to the socio-economic and political context of poverty. That is how many times politicians can make them much more poorer by creating conflicts and promoting violence among them. At the same time they can draw tremendous amount of energy through their beliefs in spirituality to cope with the poverty.

Why should we identify the poor?

- To target limited resources properly

- Not everyone in a "poor" community is poor
- Inside a family, women or children may be "poorer"

Why do we need to **identify the poor**? When we work with communities, we find out that all persons in that community may not be poor. We know that even when we work with slum communities, some of the persons living in slums are not as poor as some others. They may even be well off but they live in slums for various other reasons. Also within a family, some persons may be more vulnerable and so if you work with the whole family, you have to make sure that those more vulnerable members benefit from it. We know that, within a family, the poorer and more vulnerable are likely to be women, children, disabled persons and elderly persons. So it is important to have some indicators or clear criteria for identifying the poor. These can become parameters for our work and help us to reflect on why we are working with one poor group and not with another group.

Some Examples of Criteria for Identifying the Poor

- Grameen bank (Bangladesh)- Poor are those who do not have more than 0.5 acre of land and whose annual in-come is less than annual in-come from 1 acre of cultivable land according to local rates
- Ikhtiar (Malaysia) – has a test considering all landholdings, assets and income of persons for identifying the poor.
- BRAC (Bangladesh) mainly targets landless peasants.
- WATCH (Nepal) – works mainly for landless peasants and "low-caste" women.
- Maryada (India) - does participatory appraisal for identifying the poor.
- SCF (Sri Lanka) - works mainly for women-headed house-holds, single mothers, landless with 3 or more children

What do we mean by poor or poverty groups with whom we are working in community development projects or community-based rehabilitation projects? These **criteria** should be verifiable, they should be not subjective. While developing a project, these criteria should be discussed with the target groups and the target groups should participate in deciding the criteria. If they are the ones who will decide it then the project activities become more effective because they become owners of the decisions of including some people and excluding others. Poverty is a dynamic concept. Those who are poor today should not remain always poor, their situation should change and it should change for the better. Given that the condition of poverty is dynamic, support for the poor who are presently socially active, may not protect them from a reversal of fortunes tomorrow. A sustainable approach to poverty reduction therefore requires a combination of social development and social protection measures to ensure that the improving poor continue to improve; the coping poor graduate out of their precarious state, and the declining poor have an opportunity to reverse their condition. (Susan Loughhead, Onkar Mittal, 2000). So we need to have

regular evaluation of our work to see how the situation is changing, how the other groups can come and get benefit, and those who have benefited they can go on their own and help others. For doing these kind of evaluations workers have to be extremely careful in judging, in evaluating, in appraising the situation. ■

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Strategies to Reach Disadvantaged Groups in Society

EXPERIENCES OF COMMUNITY-BASED REHABILITATION (CBR)

Maya Thomas

I shall like to mention another point before I start my presentation - yesterday we discussed criteria to identify the poorest persons. One criteria which, I would like to add to what was said yesterday by Usha, is that households who have persons with disability are also among the poorest. Far too often, when we are considering poverty alleviation and development programs, persons with disabilities tend to be left out and do not get access to development programs, because they are not specifically defined as vulnerable group to be included.

My presentation will be based primarily on my experience in the field of **community-based rehabilitation** in different countries in Southeast Asia and Africa. I really do not have experience of working with other disadvantaged groups, so I do not know much about poverty alleviation, or gender-focused community development programs. However, in the course of having worked in the field of CBR over the last 15 years or more, I have had occasion to observe relationships between CBR, community development, poverty, disability, the changes that have taken place, particularly in the field of CBR over the last 15 years, and how things are moving from a services delivery approach based on medical-oriented model to more of social and development-oriented models in the field of CBR. I think that there are a lot of lessons that we can learn from these experiences and observations of changes in CBR, to apply them also to our discussions today. So my points are based on my experience in the field of community based rehabilitation, but I do believe that there are issues here that we can use in our discussions as well.

Before we look at strategies to reach disadvantaged groups, I think we need to spend a little time on analysing **why do we need to develop such strategies**? There is a need in talking about **developing strategies**, because we know that disadvantaged groups, which include persons with disability, are generally left out of a lot of development programs and out of the development process. Why does this happen? Yesterday we heard some reasons from Sunil in his introductory speech, but let me add on to some of them.

One example, which I want to deal with, is the example of micro-credit programme in Bangladesh, which is very famous. I mean **Grameen Bank** has made it very famous all through the world. In 1998, there was a study done for NOVIB, a donor agency from Netherlands, and when they looked at all the partners and different population groups that Grameen Banks were working with, in the field of micro-credit, they found that the "hard core" poor were really left out of these micro-credit programmes. When they analysed those "hard core" poor, which were left out, they found that some women groups, persons with disabilities and people who had no access to any kind of development programmes were not benefiting from Grameen Bank. So this study found that the "hard core" poor were not really part of these micro-credit programmes, why did it happen?

One of the reasons for this exclusion that this study found was that the "hard core" poor, which includes persons with disabilities, are not perceived as "credit-worthy", they are so poor that they are not able to contribute in terms of savings, they are not able to repay the loans that they get, so in other words they are not, credit-worthy. This is as far as micro-credit schemes are concerned.

Secondly, these poorest persons **lack the skills** to manage micro-enterprises. So in the context of lack of education and skills training, they do not have the capacity to manage a micro-credit programme.

The third reason was the **attitude of charity** and expectation of free welfare and benefits on the part of the "hard core" poor. The fact that they were so used to doles and handouts that they continue to expect the same, and therefore the spirit of initiative and enterprise was missing.

The forth reason was about taking away of large parts of benefits of the programme by some minority groups. Here I am not talking about minority group of persons with disabilities or other disadvantaged, but about certain **powerful minorities** in the community. In Bangladesh, it was interesting to learn that there are some powerful money lenders in the villages, who send the women to ask for micro-credits, because most of the micro-credit programmes in Bangladesh target women. So money lenders gathered a group of women, sent them to the different agencies to collect credit, and then used the money that they got for their own purposes. So a powerful minority of moneylenders in the village exploited the entire micro-credit programme for their own benefit.

As far as persons with disability were concerned, lack of mobility was one major barrier for them for accessing micro-credit programmes. Other barriers included, **lack of positive policies** on the part of organisations that promoted micro-credit schemes, and **lack of training** in disability issues for personnel working for development programmes and micro-credit programmes.

So I think that some of these reasons, which prevented the poor and disadvantaged groups from joining micro-credit programmes, probably are the same reasons why these groups are also left out of a whole lot of other development programmes, largely because they are not seen as capable. I think these are the many reasons why the "hard core" poor and the disadvantaged groups tend to get left out of development programmes as well.

Strategies – Organising Groups: One of the strategies in any development programme, and this is an understanding which has grown also in the field of CBR, is that we need to organise groups, we need to organise persons with disabilities or other disadvantaged groups, in order to include them into the development process. All these concepts of participatory strategies, community participation, the social model in CBR, all of these are concerned with organising communities, with the end goal of **communities taking charge** of their own development or of their own programmes.

This process of organising communities, particularly communities in poor countries, is a process, which is fraught with a lot of difficulties. Let us look at these difficulties as well, because we need to keep these in mind when we are looking at strategies to include disadvantaged groups in the communities. One of the major difficulties in organising groups, organising communities, issues related to community participation, community control, ownership of programmes, is linked with the diversity that we find in any community. Generally when

we talk about communities, many of us who are not in the field, tend to have a very romantic, idealistic notion of what a community is. We tend to think that communities are very homogeneous, very cohesive, very mutually interdependent, and these are some of the assumptions that we tend to make when we talk about the community. International development experience has shown and it is documented that this assumption is completely unreal and that there is nothing like a homo-geneous community anywhere. **Communities are heterogeneous**, diverse in terms of social-economic status, educational status, religion, culture, and ethnicity. For instance in India we have the caste system. So all these differences make it very difficult, not only to co-ordinate services in a com-munity like this, but also to promote com-munity participation, involvement, orga-nising groups and getting them to work together.

I can give you an example of the problem of the caste system in India. There are certain rural areas in India where different castes take drinking water from different wells. If they do not even share the same drinking water-well so how can we think of organising groups to work together? So an important point that we need to consider is - **who therefore constitutes the community**?

In many CBR programmes, particularly in many urban-slums CBR programmes, one finds that, when we talk about the community, very often it gets translated into parents, families, and, more specifically, mothers. So it's important for us that when we are talking about organising groups and organising communities, to first understand, who is the community, how do we define this community, what are the kind of differences that exist in that community, before we can start planning to organise or plan for integration into development programmes.

The next set of issues related to organising community groups is related to the widely varying and **different needs of groups** that can be in conflict with each other, for example among persons with disabilities. In any community we find that persons with disabilities and their families constitute a minority group, in terms of absolute numbers. When we are talking about development programmes for the community, the **needs of the majority** community have nothing to do with the needs of persons with disabilities, in fact the needs of majority communities are always about health, sanitation, water, education and health care. So rehabilitation services and needs of persons with disabilities come always last, sometimes they do not even figure in the list of community priorities. This raises issues of **access and equity**, which we will be discussing tomorrow.

The next set of problems related to the NOVIB example in Bangladesh has to do with corruption, which is a reality in many of our countries. **Vested interests**, groups with their own interests, the powerful minorities, they have nothing to do with persons with disabilities or other disadvantaged groups, but generally with the **political support**, they tend to corner most of the benefits of development programmes. In fact, during our travel for coming to this workshop we were talking about this subject and about a joke, but it is also a pretty disturbing joke, that one politician, when his daughter got married, he gave her some NGOs as dowry. In India we have the system of dowry, so when a daughter gets married her parents must give money called dowry. Thus NGOs are seen as a good income generation activity for the rich and powerful, rather than an

organisation for promoting development. These rich groups they are interested in cornering of benefits. They feel that NGOs must be getting a lot of money from donor agencies, so they seen as an income generation activity.

In another example from another state of India, a CBR programme tried to involve local leaders in the programme and they found that the local leaders and the local politicians were very interested in the programme. When NGO talked to them, they offered their full co-operation and every assistance. One year later they found the reason for this interest - the leaders were expecting to receive a percentage of funds. When they found out that they were not going to get any funds, they lost interest in the programme very fast. So these issues are very real – corruption and cornering of benefits, and we have to deal with these, when we are discussing community development programmes.

To continue our discussions about some of the problems, another important issue is that of the **mind-set and attitudes**. This is a very big barrier in any community development programme, which is looking at issues of equity, access and including disadvantaged groups in development programmes. On one side, we have the mind-set or attitude of the community, where they expect benefits and are reluctant to take charge of their own development. This is a common problem for different groups, whether they are persons with disability, other disadvantaged groups, persons affected by leprosy, or poor people. It has been said that there are historical reasons for this as well, because many of our countries have had **colonial pasts**, followed by varying forms and varying interpretations of socialist forms of governments where the state is expected to take charge of all welfare and development programmes. So because of this history, many of our communities are not ready to take charge of our own programmes and development. The expectation is that the government should do it. "Why should we?" they ask. And if we are asked to take charge of our programmes, it means that the government is abdicating its responsibility. So these are some of the mind-set issues that we have to deal with, the reluctance to take charge, and expecting somebody else to look after us. All these issues are at the level of the community.

There is another big barrier at the level of the service providers, usually NGOs and in some instances governments. Many service providers are very comfortable with their **role of service provider** and they do not want to shift to the role of being a facilitator. They are afraid of letting go, of loosing control, of loosing their empire building, because there are many NGOs which have built huge empires, buildings, infrastructure, control and political ambitions. So it means letting go of all this if they become facilitator rather than a service provider. In fact one such NGO very clearly told me that, "Well what we will do? What will our role be if the groups that we are working with become empowered?" So the need to change the mind-set on the part of the service providers from being a service provider to a facilitator, that we are there to facilitate development and we are not there just to give services, that is another change.

Of course there can be other problems, like in rural Nepal, of difficult terrain, remote areas, mountainous areas, where you have to walk for several days to reach some isolated villages. Thus **difficult terrain** is another barrier to organising groups and to facilitate their access to development programmes.

Self-help Groups: One strategy or

approach, which I found to be quite useful whether it is for working with persons with disabilities or with women, is organising **self-help groups**. Literally self-help groups means a group that gets together to help themselves for various purposes. In general now in India the term of self-help groups tends to be associated with micro-credit work, but it is not only for micro-credit. A self-help group is a group that gets together, it is a relatively **homogeneous group**, with common interests and when persons get together with a common objective. It could be an instrument for micro-credit programmes and it has worked quite successfully in parts of India for micro-credit programmes.

So I think that self-help groups strategy for organising groups is one that we should be able to look at. Second thing is that when we are promoting self-help groups and other kind of organisation work, we need to keep in mind that we have to play a **facilitators role**, we need to build capacity of the groups that we are working with. It is not enough to say that we organise them into groups and leave them. Many of such groups face many barriers. As I said earlier, they have lack of skills, lack of education, so groups once organised, **need to be trained** in management skills, accounting skills in the case of micro-credit, leadership skills, communication skills, in order to be able to lobby with other agencies like government, banks, other development programmes. So we need to spend a lot of time on capacity building, keeping in mind that our role is that of a facilitator, and that we are not going to be with that group permanently.

Once self-help groups are formed and sufficiently trained in the skills that they would need to manage themselves, they need to have access to credit programmes and access to other existing development schemes, whether it is from government or from others NGOs or banks. Providing these groups **access to credit** and to other schemes would be of great help to them. Again we need to keep in mind, our role is to just provide that access, our role is that of a facilitator not a service provider, to facilitate the access and then leave them to follow it up and to manage on their own, which they would be able to do it very well if we have done a good job of our capacity building.

Attitude change: This is something which also requires a lot of input, also takes a lot of time, and sometimes it is very difficult to achieve a change of attitude on the part of the communities, to shift from expectations of benefit to take charge of their own programmes. The second attitude change we need to bring about is on the part of the service provider, from change from being a provider to become a facilitator. Both these changes take a lot of time and are not very easy, but it is important to concentrate on these strategies of attitude change.

Developing Role Models: There is one more strategy here, which I have not mentioned so far. The strategy to develop role models, identify some **key people** within the communities where we work, who can make a change. When we can't change the attitude of the communities, help them to become, to become leaders in the self help groups, make them into role models to motivate and enthuse others groups. So identify and develop role models of persons from the groups that we are working with, is another strategy that we need to build up. When the rest of the community sees successful examples of role models, obviously their attitudes and motivations will also change. Nothing brings success like success they see, so developing successful role models is another issue that we need to keep in mind. ■

Identifying the Poor – Group Discussions

Who are the poorest? How do you identify them?

Persons who are in conditions of absolute poverty include – those, who do not have access to basic essential services like drinking water, basic education, etc.; those, who do not have basic facilities for living like a home, their land for cultivation, animals, etc.; and those, who do not have sufficient economic means to survive with basic dignity.

Poverty means different things in different parts of the world and there can not be a common definition. Poverty is also a relative concept and depends from historical conditions. Keeping this in mind, the following groups can also be considered as poor – persons, who are excluded from different political, productive, educational and health processes; those, whose rights and duties are not recognised; those having low self-esteem; those who loose their cultural identity; those who are ashamed about their ethnic origins, perceiving it as the cause of the deterioration of their quality of life; those who are bound by "false" necessities of life; and, those who are not able to defend themselves like orphans and street children.

Among the poor, which groups are more vulnerable?

Poverty creates a vicious circle, so that better-off groups benefit more from development interventions while the poorer and more vulnerable groups have more difficulties in accessing and benefiting from development interventions. As far as the question of persons, who are worse off among the poor, different groups include:

- Ethnic minorities are usually worse off, compared to majority groups. In India there is the caste system, people belonging to "lower" castes are targets of social discrimination. Persons belonging to tribal and indigenous groups, usually live far away from cities in isolated areas and forests.
- Women in general and widows, single women, women deserted by their husbands are worse off. In some countries women are branded as witches and are regarded as persons, who are able of doing witchcraft and they are socially ostracised. Illiterate women, wives of alcoholics, wives of men who work at far away places so that the responsibility of managing household is on these women, and wives of men who are at war are also worse off among the poor.
- Persons with disability, persons affected with some diseases, which are associated with social stigma like leprosy, AIDS, venereal disea-ses, tuberculosis, etc. are worse off.
- Displaced communities, refugees of war and natural calamities, victims of disasters and migrants are usually worse off.
- A new class of poor is rising, people who become poor because of losing jobs because of new policies and new labour saving technologies adopted in industries.

- Elderly people without social and family support systems are often worse off compared to others.
- Those who do not have their own income, those who are not involved in productive activities like children, disabled persons and elderly persons.
- Those, who do not any choice or alternatives like prostitutes, refugees, prisoners, etc.
- Those, who lack the voice like mentally disabled persons, persons suffering from terminal diseases, infants killed at birth or killed before birth.
- Persons who have lack of opportunities for self-development due to lack of education, lack of professional qualifications, lack of identity

Is Poverty different in Rural and Urban settings?

Rural poverty is characterised by isolation, long distances from any public or private services, more fragile economic and alimentary situation, also because in rural areas, persons are more vulnerable to climatic conditions, natural disasters and wars. In the rural areas community organisation is easier than in urban areas.

On the other hand, urban poor also have economic and alimentary fragility but reasons may be different because it may depend upon the kind of work a person is able to find every day, so their situation varies daily. At the same time, some times in urban settings, the family, social and community relations and references may be threatened, so the poor families can not respond to the stress of poverty. At the same time, in urban situations the general life conditions show greater degradation and stress (for example from criminality and prostitution), especially for some groups of persons like street children. In urban areas goods and services are available but the urban poor have less access to these compared to the better-off persons. At the same time in urban areas, there is greater influence of mass media and other communications, so that people are incited to be more consumistic. The urban poor, because they live in the midst of plenty, there is more frustration and anger than in the rural poor, which very often lead to violence and crime. Planning any specific interventions for urban poor may be very difficult since their numbers are enormous.

Measurable Indicators for Identifying More Poor and Vulnerable Groups:

Any direct indicators for identifying the persons who are more at risk and are more vulnerable should not be defined a priory, because these indicators are very much dependent upon the local context. For example issues like – how many times does the person manage eat in a day, what kind of food can the person get, what kind of clothes can the person wear, etc. can be useful in some contexts. Such criteria and indicators should be defined on the basis of priority needs identified by the communities.

Some of the possible indicators can be linked to factors like - the ownership of land in rural areas, the ownership of house in urban areas and access to means of livelihood. Each country may have its own policy regarding people who are behind the poverty line, and this could be another criteria for deciding.

Identification of objective and measurable criteria should be in relation with geographical areas and kinds of interventions. For example, in a group of Yanomami in Brazil, we may look at issues like malnutrition among children, number

of new disabilities due to leprosy, etc. On the other hand, depending upon the type of intervention like access to land for landless peasants, maternal education, public awareness campaigns, etc., we may need to look at different specific groups in the communities. ■

Voices of Participants

Alberto Porro/Brazil
All interventions related to health and education must involve the local public authorities, as these are duties of Government and we should make sure that their responsibilities are not taken away.

Sarmila Shrestha/Nepal
Poor people should be invited to such discussions. It would be more informative like what people living with disabilities have shared with us their beautiful experiences.

Dorte Chorei/India
Involvement of target group should lead to empowerment. Target group are not object of development process but they are the subjects of changes. Social service should lead to social action.

Cresentia Toppo/India
I know poverty in my country but I now realise that there are many countries that face the same way.

Equity & Access to Health & Social Services Experiences from Congo

Chiara Castellani

For me talking about equity means talking of something that is real and not an abstract principle, that was part of my two contrasting experiences. For seven years, I worked in **Nicaragua** with Sandinist Government. About the policies of that government, there may be many criticisms, yet undoubtedly, it was a period in the country when access to essential drugs was guaranteed. Access to preventive and curative services, especially for the poorer sections of the society was guaranteed. The health services did have clear criteria like to give priority to groups like children, pregnant women, tuberculosis patients, etc.

Then in 1991, I came to **Congo**, which was called Zaire at that time. I was very new there and I saw a sixteen-year-old boy, to whom I diagnosed appendicitis and proposed that operation was necessary. However, I was shocked because the boy was not operated till the family could put together the funds for the operation. By that time, the boy already had peritonitis and any way, the family did not have money to pay for antibiotics. Thus that sixteen-year-old boy died in front of me, a stupid death, which shocked me since I was coming from a completely different context.

These last 10 years in Congo have been a continuous battle to ensure services to those, who do not have the money to pay for the services. As far as access to essential services and drugs is considered, in our area of Kimbau, the situation is quite desperate and it is not easy to find solutions. To look at the question of equity, let me start with a story called, "Death of Mrs. Victorine".

Why Mrs. Victorine is dead?

- Too many child-births, one after another
- The pressure from the family for another child
- Malaria and anaemia
- Poverty and isolation
- No Anti-natal check-up
- No prophylaxis or treatment

Among the many tragedies, which are part of life in Kimbau, there is also the story of Mrs. Victorine. Victorine was also a good friend for me. She was together with my close friend and guide, Dr Isha, our old doctor who worked as chief medical officer and who was shot dead by military because he was originally from Rwanda. Victorine stayed with him till, his very end, refusing to leave him. Then she fell in love with Albert, who is from another village. They were married and so Victorine left us to live in Albert's village. I was informed, when she lost her first baby. It was a spontaneous abortion and she had bad haemorrhage. She should have been waited for some time before become pregnant once again, but there was family pressure. She had "failed" once and she had to prove it to the family that she was a fit wife for their son. However, she was not fit to have another baby so soon. You know, in malaria endemic countries like ours, if there are repeated pregnancies, the risk of anaemia become

much higher. In the place, where Victorine was living there was no possibility of treating her anaemia, there was no prophylaxis against malaria, and there were no iron tablets for her.
They did have a peripheral health centre in her village, but in a country where health services are not organised, for economic reasons, nurses become transformed in to merchants and every thing is only for sale, only if you can pay the price.
They did not even have Chloroquine in their health centre. There was no iron, no Chloroquine, both drugs needed by Victorine during her new pregnancy. During that pregnancy, she did not go for any antenatal check-up. I came to know about all this, much later.

WHO has made a video, "Why Mrs. X is dead?", where instead of Victorine, they have an "X". To that video and that story, I have given a name. I had seen that video and it had been impressed in my mind as the story of a woman, where the medical intervention is too late and after a futile caesarean section, both mother and the baby die.
WHO says that it is a true story. Victorine's story is even more real. She did not even get any caesarean section, as she did not have enough money to pay for any operation. She died along with her baby, without any one doing any thing to save her or her baby. Why did she die?

They called on the radio, "Come quickly. Victorine is sick". Actually, they did not call me or ask for me. The message was for Victorine's father. I only went along because she was my friend. When we arrived in Kenge, she was already dead. I could not give myself peace. I wanted to know, why did she die?

Why did Victorine die?

- Family pressure for a child
- Fear of being sterile and childless
- Absence of antenatal assistance
- Lack of medicines for prophylaxis and treatment
- Lack of work and gainful employment for women
- Patriarchal family structures
- Women's role confined to child-bearing
- Poverty and lack of essential drugs in the health centre
- Husband was absent – husbands decide about their wives and children
- Nurse was absent – no salary for one year – looking for alternative income
- Doctor was absent – gone to a polio seminar

There was no antenatal check-up, no assistance for childbirth and then, during delivery, there was a haemorrhage. Perhaps, in the beginning, it was something small or may be it was placenta previa or placental rupture – we shall never know, because there was no trained obstetrics nurse, not even a trained traditional birth assistant. WHO documents talk of refresher courses for traditional birth assistants and we had such programmes in Nicaragua, but in Congo, such programmes do not exist even on the paper. There was one old traditional birth assistant, who does not know any thing and is without any other training, so we shall never know, what kind of haemorrhage it was. There were so many other things. She

was brought late to Kenge because her husband was not at home when the pains came and the child was not coming out. Husbands decide if wives and children can be taken to hospital or not. If husband is not there, you can not take a woman to the hospital, so this is the first obstacle to reducing maternal mortality, apart from all the other obstacles about access to services, access to drugs, and other things, which are told in WHO books. I know already that in poor communities so many more women die during childbirth than in richer communities. But, the differences I see even between poor countries like Nicaragua and Congo. In Congo, so many more women die, who could have been easily saved.

Most Common Causes of Death
Diocese of Kenge

- Malaria
- Tuberculosis
- Sleeping sickness
- AIDS/Sexually transmitted diseases
- Measles
- Meningitis
- During childbirth

The obstacles are many. There are delays in deciding to come to hospital. Even when you decide, there are no means of transport. Often, they carry you in makeshift trolleys made by people. When you reach the hospital, the nurse and the doctor are not there – they have gone to the polio seminar. Polio programme has lot of money and each programme wants its own seminars and activities.

Polio is an important cause of disability, and in the past, it was one of the most important causes of permanent disability. Like the eradication of smallpox was a big victory for medicine, probably eradication of polio will also be a big victory for humanity. So I can understand, why we must invest billions of dollars for polio eradication, but it is not right that in a country with so many health problems, the public health services are worried only about polio. Similar criticisms have been shared with me by doctors and nurses working in other countries as well. In Congo, our health budget is already minimum, thanks to the structural readjustment programmes and the cost of this never-ending war. The amount kept for health services to 50 million Congolese people is just ridiculous and even that budget goes mainly for polio. As if polio is the only problem of public health in Congo, so all the space in the refrigerators is only for polio and there is no space or money for measles vaccines. Other vaccines are no longer important and so, they are not available any more.

To continue with the story of Victorine, I have tried to analyse the reasons of her death. **Family pressure** for a child, her own fear of remaining child-less in a patriarchal society of *Baiyaka*, where men decide everything on the lives of women and children. Husbands decide who can be cured, who can go to school, everything. Add to this lack of access to health services. Health services follow the rule of free market. If you have the money, you get the treatment, if not, you are condemned to death. The same free market rules education. If the family does not have the money to pay to the teachers, your child can remain illiterate and stay at home. If you have to chose between male child and female child, the final answer is the same as in so many other countries of the world. Illiteracy means lack of decisional power for women. It means that their role remains confined to reproduction, so the terror of sterility is natural. It is true that there are no

family planning services, but Victorine did not even look for such services because family wanted that she produce a child quickly.

There are **no medicines** in the health centre, because these never arrive from the central hospital. When drugs do arrive, these are not the essential drugs, but are other market-driven drugs. Drugs, which are some times prohibited in other countries because they have too many toxic side effects, are still being sold and used in Congo. Vitamin injections are another group of medicines, which come regularly and are used extensively. I feel as if I am fighting against windmills, all my never-ending battles. Useless drugs and injections come to the health centre but not the essential drugs. For Chloroquine resistant malaria we need Quinine but we get injectable Chloroquine. The free-market rules the drug supplies. Every nurse, without any salaries for months, easily transforms into a merchant, willing to sell anything and every thing. All merchants, who come there with their trucks, bringing the medicines, become nurses and sell drugs to the public. There was **no money** to pay for caesarean section and any way the doctor was not there to operate her. He was in Kenge for the seminar on polio, because in the seminar you get per-diems and when you do not receive salaries, all per-diems are more important than this woman, who had a haemorrhage but did not have the money to pay for a caesarean section.

So lets come back to try to understand. Poverty, lack of essential drugs, absent husband and absent nurse – he prefers the polio seminar because that is the only way in last twelve months that he would receive any money. What are the common features you see here? Unpaid salaries, war, female illiteracy. In Congo, I do not think that there is that prejudice against women, which is there in some other countries. If free schools were available, I am sure that all female children would also be sent to school. If education was accessible, the women would study as the men do. In a family if resources are limited and you have to pay for the education, you can be sure that only boys will go to the school and not the girls.

We can also look at the health priorities of Kenge diocese hospital. Look at that list and you can see that among important causes of death or of permanent disability, there is no mention of polio. There are other priorities, much more important, which cause death and most can be prevented, like those from malaria.

Malaria is single most important killer disease in our population. Why do people die of malaria? Because of all those delays. The delay in decision to take the child to health service, even when every one knows that situation of a child is grave, where is the transport? Even if you come to hospital and you have money to pay, who will get assistance first? If you speak French, they will see your child first. If you a rural mother, who speaks only Kiaka and who, stands silently next to her dying child, her child will die before the doctor has the time to come and see her. You die of malaria, because it is almost every where resistant to Chloroquine and it is resistant to Fensidar. It is not yet resistant to Quinine but soon it will also be resistant to Quinine. According to WHO, a woman weighing 50 kg needs to take Quinine 500 mg three times per day for 7 days, 21 tablets. But if you do not have enough money and also because Quinine is so costly, in the end she buys only 12 tablets. Sooner or later, malaria will also become resistant to Quinine. After incomplete treatment, after a few days, the fever comes back. Persons

dying from malaria die with heart failure, with pulmonary oedema, with anaemia, which complicate partial, late, irrational and incomplete treatments of malaria.

Second big problem is **tuberculosis**. The ILEP association, DFB provides the anti-tuberculosis drugs to the country, but it is not easy to get these drugs from the capital due to transport problems. But at least, we can provide free drugs and find some local solutions to receive these medicines from the capital.

Everyone knows that I am biased towards our TB patients and as far as possible, we try to reduce their sufferings, while they stay with us for two months of in-patient treatment. However, all my efforts to transfer them in the peripheral health centres have been in vain. They do not need to come to Kimbau hospital for this treatment, which can be in a health centre much nearer to their homes. But our health centres do not want them, saying that they "do not have the possibility of "isolating" them and there is risk of infection". We try to help them with food as well. We make sure that they take their daily dose of medicines. DFB is very efficient and makes sure to supply the drugs to the national level. But if our own health system does not work and our head of health services is busy in polio meetings and other meetings, so our medicine supplies are interrupted. Patients get angry with us and rightly so. We tell them to take the medicines regularly and then we ourselves do not have medicines for regular supply. I call this "iatrogenic abandonment" of treatment. If malaria is the biggest killer of children in our area, then tuberculosis is the biggest killer among adults for us.

Third priority problem for us is the **Sleeping sickness**. Yesterday, I heard that out of 1200 new drugs only 11 are there for tropical diseases. For sleeping sickness we are still using the old and toxic drug, Assobal. This year, the drug arrived after the expiry date, so what are we supposed to do? Do I send back my patients to their homes to die?

Actually, there is another drug, a derivative of Ornithine called Florinithine, which is effective for sleeping sickness. But it is not produced as it would be useful only for treating some Pygmies in central Africa or for some indigenous rural women in Congo, it is not useful for the sales. Our populations do not understand, as they are more afraid of sleeping sickness than of AIDS, perhaps because if you survive it, sleeping sickness destroys the brain functioning. The drug we use, Assobal is an old drug – it has more than 50 years. About 2% of persons taking Assobal die from its toxicity. Fifty years ago, they did try to study this disease and to find a medicine because at that time there were Belgians who were falling sick from it in their colonies. The whites were at risk, so they studied it and tried to find a remedy – they came to Assobal and every thing stopped there.

Flornithine is not of interest to any one, there is no money from its sale.[1]

About **AIDS** I do not want to say much, only because I do not have any personal elements to add to the debate. I admire the battle fought by NGOs and advocacy groups including AIFO, MSF, etc., so that 95% of patients living in developing countries, who do not access to drugs can receive these drugs. AIDS is a problem in Congo as well, worsened by the war. The

[1] Following the campaign in 2001, it has been decided to provide Eflorinithine free of cost for five years through WHO.

military is a big risk group but it is difficult to talk to them and to convince them about use of condoms.

AIDS and **sexually transmissible diseases** are closely related. The war has had an enormous impact on the diffusion of AIDS. I have heard some persons say that if anti-AIDS drugs are supplied to poor countries, they will not take them regularly and just create drug resistance. My experience from TB is completely contrary to this view. If persons are educated about their disease and can have access to drugs, they do not abandon the treatment. However, in a country like Congo, where people talk of high risk of AIDS, you can go all around Kinshasa and you will not find the reagents for controlling the blood for transfusions. So we have to very careful about blood transfusions and we them only when it is absolutely life saving, since we do not have any way of checking the safety of our blood. So blood transfusion can be only a last resort, like a child, who is going to die from malaria, but we are never sure if we are not using contaminated blood.

I have put together AIDS and other sexually transmissible diseases because there is an epidemiological double connection between these two. On one hand, in South of the world, the main way of transmission seems to be heterosexual, while in rich countries it seems to be different because of its greater prevalence in homosexuals, because of fragility of anal mucosa. In Africa, syphilis and gonorrhoea are still very big problems. For me these are more urgent problems since I see them every day. Not because they have more un-protected sexual relationships and lesser use of condoms. It is true that condoms are less used, also because they are not easily available in automatic distributors as in Europe. But, there is another aspect, the cultural aspect. It is difficult to tell a couple about condoms, when you know that they are trying to have a child. Even more difficult is the problem of access to drugs. As I am a gynaecologist, I even receive couples from as far as Kinshasa, who are hoping for a child. Often one of the things related to the sterility is complicated gonorrhoea, due to incomplete treatment. They start the treatment but do not complete it because they do not have enough money. So they go the nurse-merchants or to merchant-nurses, who do not know the proper treatment. Thus there is drug-resistant gonorrhoea. 95% of sterile couples that I treat have problems due to incomplete treatment or drug resistant gonorrhoea.

Measles is another problem and here I have to speak once again of the vaccines. Last year, when we had the third campaign of polio vaccination, we were promised that next time, along with polio vaccine, we shall also get measles vaccine. So we had prepared the persons and since there was already an explosion of measles in our area, people were motivated to come for vaccination. When the vaccines came, there was only polio vaccine and no measles vaccine. I felt that they were so cruel, making us believe that it will come. 35,000 persons had come for the vaccination with their children because measles was killing children. But no one is interested in measles. To USA, only polio is interesting because they want to eradicate it even if there is some risk of post-vaccination encephalitis. They first try with the war and throw bombs on our people, then they bomb us with anti-polio vaccines, nothing else counts, and measles does not count.

Meningitis. We had an epidemic of meningitis in 1997, after the massacre in Kenge. Of maternal mortality, I have already spoken.

Most Common Causes of Permanent Disability - Diocese of Kenge

- Onchocerciasis
- Leprosy
- Konzo disease
- Diabetes
- Thyroid disorders
- Iatrogenic problems (problems caused by health personnel)
- Road accidents

If we look at the causes of **permanent disability** in our area, polio is not there. Certainly, Congo is one of the last reservoirs of wild polio virus but in countries where breast-feeding is prolonged for at least one year, the risk for polio infection below one year is much less. I know that for infection after one year, the risk of paralytic poliomyelitis is much higher. Still there are other important causes of disability.

Onchocerciasis is the most important cause of blindness in our zone, much more than leprosy. When I went to the national office for Onchocerciasis to get some Ivermectin, they told me that I was the last person who asked for this drug and they did not have it. But last time I had been there was in 1998. Why they do not have it? I know that it is distributed free of cost through WHO. I have experience with Ivermectin in Ecuador. But here, the Onchocerciasis programme does not work. I know that Congo has Onchocerciasis, we have cases in Kimbau but not according to the national office.

The Insia river, which passes below my home, is an important source for Tze-tze fly and other flies. There are so many persons, blind due to Onchocerciasis but no one wants to do any thing for it.

Leprosy is another problem in our area. Fortunately for leprosy, I do not have any problem for drugs since it is guaranteed to me by DFB, while AIFO helps us for other essential drugs. For leprosy the drugs are there but because of the war, it is not easy to go to the national office regularly to take these drugs. Another problem is that of finding petrol for going around and getting all these drugs. Our roads are unimaginable.

We have another cause of permanent disability – the disease of **Konzo**, which causes permanent motor paralysis. In our language "Konzo" means "a little magician", who can bind the legs of persons, stopping them from moving. Once you have it, you can not walk any more.

A few years ago a team from Sweden came to study this strange disease, which appears each year at the end of dry season, especially in the desert areas in Southwest part of Kimbau. In this zone there are no trees. Environmental desertification is a common problem in our area, also at Kenge, which is all full of sand. In the sand, the only thing that you can grow is Manioc, which adapts to all climates. This manioc plant was imported from Brazil. It is rich in cyanide, a bitter kind of manioc. To remove the cyanide, there are traditional ways like leaving it in running water for five days. But if you are hungry and can not wait for the five days to pass, what do you do? So persons eat it after only two days of cleaning in running water, insufficient to remove all the poison. If you can eat some thing having proteins (like amino acid Cysteine) with it, then its toxicity can be reduced, otherwise you may have acute poisoning with a spinal lesion resulting in spastic paraparesis, which may be irreversible, especially in children and breast-feeding women. The epidemics of Konzo in our area, studies have proved it

through analysis of cyanide residues in urine of the patients, are due to cyanide derivatives in manioc. At the end of the dry season as people do not have any thing else to eat, new cases occur. The same toxins also result in chronic calcifying pancreatitis along with diabetes. We have high number of diabetes due to this, even if our people do not normally eat any sugar or sweets. This means that the damage to Pancreas is both to its exocrine and endocrinal functions.
So these persons are insulin-dependent and you can imagine all the related difficulties, as we are in a place where often there is no electricity and it is not easy to conserve insulin and people are scattered in inaccessible villages.

Let me talk about **iatrogenic permanent disabilities**, that means, disabilities caused by mistakes of the health personnel. These may be due to lack of essential drugs or use of non-essential drugs and sometimes abuse or improper use of medicines. For example, Quinine has to be given by mouth or as an intra-venous drip but it should not be given as an intra-muscular injection as it will cause necrosis. However, often "nurses" can make intra-muscular injections of Quinine, some times exactly over the sciatic nerves, some times with un-sterile needles. Injections of Quinine over the sciatic nerve made by "merchant-nurses" are one of the important causes of permanent disability in our population.

Even **traffic accidents** are an important cause of deaths and disabilities in our area. I know it sounds absurd to say this, when there is hardly any one with a car or jeep in Kimbau.
However, lack of transport also means that there are trucks going around with hundreds of persons hanging out from different sides. Given the state of our roads or non-roads, often they turn topsy-turvy and crash along the side of the roads. Thus every accident kills not just 1-2 persons but 20-30 persons. All those who find themselves on the "wrong" side are cru-shed underneath, dead or disabled.

Some Temporary Solutions through External Support

- Donations of essential drugs
- Donations of funds for buying petrol for guaranteeing some minimum transport
- Contribution for health personnel's salaries
- Salary for the hospital doctor
- Supply of milk and rice for the patients

We do not have any permanent solutions to our problems. Our aim is to promote development but it is such a slow and fragile process. Our temporary solutions are based on external help like the help we get from AIFO. All other international partners have abandoned us as they say that they do not want to give salaries and free drugs, only AIFO continues to help us. We know that if we go on like this, we are not solving our problems, but tell us what we should do? We need peace, we need roads, and we need a government...

We have started partial cost-recovery programme in our hospital, but if people are so poor, how can be ask them to cover the actual costs of a service or a drug? If AIFO will also stop helping us, we shall be absolutely zero. AIFO provides us with essential drugs, so at least we can make sure that no one should die only because they do not have any money to pay.

It is not that money solves all our problems. Even if you have money to buy petrol, what do you do if they sell it to you adulterated with water, so that you find your vehicle stopped in middle of no-where?

I agree that the principle of "not paying salaries for government staff" is good but if people have not received salaries for the last 18 months, how are they supposed to live and work? We have an inflation rate of 10,000 times annually.
Our money is just paper, without any value while the war makes the inflation run uncontrolled.
This temporary solution does not change any thing, we do not become self-sufficient but at least our staff is still here and is willing to work like honest workers, without becoming "nurse-merchants"!

For 9 years, I was the only doctor in Kimbau. Now at least we have been able to get a doctor, a surgeon from Kinshasa to work in the hospital. He is not a missionary and without a private salary, no one will come to work here in this isolated, under-developed rural desert.

Yes, it is temporary solution, but what are we supposed to do? Come have a look at our malnutrition. People die of hunger. In the past, we used to produce so much food that we could sell it in Kinshasa but now we have nothing. With war, destruction, tree-cutting and desertification, every thing is gone.
At the end of dry season, people die of hunger and we have nothing to give to the seriously ill patients. We can not buy any thing locally, we must get it from Kinshasa.

Other Measures for Long-term Development

- Hydro-electric project
- Support to training centres and schools
- Differential cost recovery system
- Rationalisation of out-patient, in-patient and emergency services

We have some rays of hope though. Finally the soldiers are going away. They had occupied our staff houses and they used to take our vehicle but now all that is better. AIFO is helping us with a hydroelectric project, so that hospital and villages can have drinking water and electricity. Our village communities are going to provide the labour. If this can function, perhaps our fortunes will change.

There are projects with schools, technical training institutes and nursing institute, so that students receive notebooks and pencils, etc. The school sells some of these things received from AIFO to pay for school fees for some of the more needy students. One day we shall have our trained technicians, nurses and medical assistants. Perhaps by that time our government will also be more stable to provide them with minimum working conditions.

We are also asking for payment for some services like treatment for sterility, while other services like care for malnourishment and deliveries can be done without payment or very low payment. Perhaps, these rays of hope seem very weak to you, perhaps we do not dare to hope a lot, but it is a beginning. ■

Equity & Access in Health – Group Discussions

The second theme for the workshop was understanding the issues of equity and access. Chiara's dramatic presentation about the situation in Kimbau in Democratic Republic of Congo was instrumental in bringing out different issues related to the question of equity and access, especially in relation to health services.

Understanding Community Health:

Health should be seen as capacity to fight against all those factors that disturb the harmony of human life. Health is joy in the body and joy is health for the human spirit. Health is not just a right, in the sense of some thing passive but is the end result of efforts of whole communities and thus requires a sense of co-responsibility. So you can not look at health in terms of health givers and target groups, it has to be seen as joint effort between people and services. People who are excluded from a productive life, like refugees, migrants, unemployed, etc. can not be expected to be "healthy". Persons who are victims of prejudices, violence, drugs, etc. can not be expected to be "healthy". Persons, who are excluded from basic minimum services of health, education, leisure, transport, etc., can not be expected to be "healthy".

Health is some thing outside the walls and outside the buildings of hospitals and health centres – it is in the persons, the context of their local communities. Inside the walls of hospitals and health centres, often there is not health but sickness-industry – the industry of drugs and there curative, symptomatic cures dominate over every thing else. It is important to clarify the meaning of community health services for understanding the issues of equity and access. Community health should be seen from communities' view-point, which is a multi-sectoral concept and also because each community understands "health" in different ways. Communities may understand the causes of diseases in different ways, which do not always coincide with the "official" explanations.

For example, epilepsy may not be seen as a disease in some communities in Africa but is rather seen as a consequence of possession of the body by bad spirits.

Another example is that of schistosomiasis with haematuria, which can be seen by some communities in Africa, as male menstruation and thus it may not be perceived as a disease.

Community-based rehabilitation may be proposed with certain ideas, but communities perceive rehabilitation in different ways according to the different contexts.

Even the request and need for health services can be very variable, as the priorities for different communities can be very different. Thus usual approach may be seen very much as a quantitative approach, as health professionals look at health indicators, mortality and sickness from different diseases, etc. This approach determines what medical professionals perceive as priorities, while the communities may see it very differently.

Even the community dynamics need to be considered, for example about the AIDS/ HIV problem. Our emphasis on prevention of AIDS may be in conflict with the priorities of families and communities, who look at reproduction and maternity as a priority rather than for limiting the families and having safe sex. The community dynamics may also be liked also to traditional medicine.

Factors Influencing Access to Health Services:

Factors influencing access to community health services geographical factors, climatic factors, lack of health policies, wars and economic wars. Then there are factors related to the suppliers of health services. The health policies are mainly decided on big numbers, aggregates and averages. These may thus exclude the poorest, those who cost too much and who are not perceived as productive. There are different examples of heterogeneity of interventions – in some areas, different districts may be running according to different policies and priorities, and some times different actors work in same areas with contrasting policies and interventions. This means that in such cases community health services are not efficient or effective.

There are also issues related to health workers. Workers are often without proper training and the training is very sectoral, focusing on specific diseases rather than on health. Health workers are not taught to think of excluded groups or poorest. Added to this are problems of corruption, low salaries or lack of salaries. Workers can also belong to different caste and ethnic groups and they may even discriminate among the clients of their services. Human factors have an important role in way health workers can facilitate or create obstacles to access to health services.

The question of costs is also linked. If health services are not a right but services with costs, benefits and pressure for lowering or limiting the costs or for recovering the costs, the poorest and marginalised groups are necessarily going to be excluded from any access to health services.

Another group of factors influencing access to health services is related to target group of beneficiaries in the communities. Some time weak persons are abandoned or discriminated by communities, like in the case of leprosy. Even the concept of the community is some times overplayed or exaggerated and in reality that same idealised concept does not exist every where. There may be poor and marginalised persons without any support from communities living near by or surrounding them.

There are also problems of lack of self-esteem and subordination to the powerful among the poor. The situation of marginalised persons may be culturally justified by generations of oppression and exploitation. The "culture" and the language of the poor may be invisible or missing because majority powerful groups do not acknowledge it or consider it as inferior.
In such situations, poor and marginalised may self-exclude themselves from services and their community participation may be very little.

Issues of Access and Equity for Disabled Persons:

Disabled persons are one of the marginalised and excluded groups in societies and communities. On the whole, only a small percent of national budgets is spent for health and education. From that,

most of the national budget priorities do not consider disabled persons.

Lack of access to any health services at community level is also a barrier for disabled persons in the communities. Looking at the issue of equity from the point of view of gender, the level of participation available to women at the community-level is low.

Considering the infrastructures, like physical environment and roads etc., the barriers are every where. For disabled persons living in mountain and hilly areas, such physical barriers completely exclude them from any access to health and education services.

Community would play an important role in over-coming any barriers. So the community has to be united and involved to improve the quality of life for disabled persons. Higher level political commitment is also needed. There is need to work with the communities, where existing services as well as community volunteers need to be trained and involved for improving access of disabled persons to the health services. To reach the communities, identification of key persons in the communities can be very useful.

On the other hand, disabled persons also need to be facilitated to participate in all decision-making so that they can develop their own potentials and capacities, so they can raise their own voice to speak to public and to political authorities for their rights.

While working with the communities, community-based programmes must make links with governmental services. A judicious use of mass media is very important to create awareness in the decision-makers.

Strategies for Improving Access:

Very much related to this is the issue of sectoralisation of the services, with vertical programmes. Even if it is known that in spite of more efforts vertical approaches do not give best results and do not have impact on overall health status of persons, they predominate in health services. To improve the access to community health services, the strategies can be many. However, it is important to look at integrated strategies, acting at different levels at the same time. For this reason, it is important to start from the concept of health as a global approach.

Reflection on need of integration of health workers in the communities where they work is needed. Some times health workers and professionals are quite distant from the communities where they work, in terms of their mentality and thinking. There needs to be bi-directional process, where health workers understand that if they have technical knowledge, communities have other kinds of knowledge, which is equally valuable and which needs to be valued and respected. It is important that the poorest and weaker groups are active part of the process of change, which is promoted. If the poor groups are just passive spectators, nothing can be done. This is very important for health education. If people participate and see for themselves the changes, which are possible, their participation can improve. This means that health workers can not just go from outside and deliver something, unless they are part of this dynamic interaction with the communities. Changes can not come only from speeches and posters.

It is important to act at the level of health policies. It may be very difficult and slow but it is very important. A lot can be said about this and some thing is being done in this direction, but it is not sufficient and needs to be strengthened.

"Equality" is not "equity", not all diseases

are "equal", but we have look at the disproportionate burden of the diseases on lives of populations. Individuals can ask for equality, communities and collective groups can ensure equity.

To improve access and equity, community awareness about health as a right needs to be made. This should be done in a way which values health as part and potential of community culture, keeping account of traditional healers, birth assistants, health workers, volunteers, popular educators, artists, etc. The learning can be some thing to give to the community, but should be with the community, seen as a dynamic transformative process and not just service delivery. Interventions focusing on vulnerable groups are useful but must involve those vulnerable groups in defining them. Health is also linked closely to education and culture, you can not look at them in isolation. If you do not know, what the community thinks about some thing, you can not "treat" it. ■

Voices of Participants

Pio Campo, Brazil
I believe that health means allowing a child to grow up, not just without the danger of sickness, but also to make sure that the child can play, love and be loved and respected in his/her role of being a child.

Eliana De Paula Santos, Brazil
Fighting against prejudices and discrimination, apart from being an act of social promotion, is also an act of love and solidarity.

Javed Abidi, India
India has about 50-60 million disabled persons. Even if we live in an "information age", less than 2% of them have any access to the education.

If we speak about the power, who takes the decisions, who has more power? Usually the clients, the disabled persons are marginalised and voiceless, while power is with foreign experts, project managers and even community workers. Planning and carrying out activities without involving the disabled persons, the clients, means that project activities will not be successful.

We have been trying to change this situation. In 1998, we had the national disability convention in which disabled persons and their families were invited to discuss issues like education, accessibility, employment, social living, voting rights, etc. Experts were also there in this convention, but more time was given to disabled persons themselves to speak about their ideas and they did participate very actively in all debates and discussions. They decided to institute the World Disability Day in India as well.

Since then, we have helped in setting up of 35 information nodes all over the country. Partners have been identified in each state capital. In addition, 75 partners have been identified at district level. Our goal is to set up a system, so that the voice of disabled persons can be heard and they can participate in the decision making.

Understanding & listening to the Voices of the Poor

Mira Shiva

In the last three days, we have been discussing issues like who are the poor? Are we listening or are we not listening to them? We are not discussing whether the poor are saying some thing, because they are. We have to ask if these voices reach those who are in the position of power to act and change the situations?

The three monkeys of Mahatma Gandhi: Mahatma Gandhi used to keep small statues of three little monkeys on his table - one closing its eyes, one closing its mouth and one closing its ears. He used to say that these statues meant, see no evil, hear no evil and speak no evil. As children in India, we were all taught this story of three monkeys and in India you can easily buy similar statues. This story is taught to us as a moral parable as part of our moral values and education. However, there is another syndrome of "three monkeys" afflicting our decision-makers.

The Syndrome of Three Monkeys – (In Persons with Power)

- Selective blindness
- Selective deafness
- Selective silence with selective Amnesia

For the persons in power, the message of Mahatma Gandhi means selective deafness, it does not mean "hear no evil". They have selective deafness because they can hear the voice of World Bank and International Monetary Fund, but they can not or do not want to hear the voices of the poor.

Then there is selective blindness. Anyone, who has worked for an extended period for any community health programme in any region, can see that the public health systems are collapsing. We can see resurgence of communicable diseases. We can see certain health problems, which we had never seen before. But the decision-makers, they do not see these problems. They have a selective blindness. Poverty lines go up and down, depen-ding on the different formulas they use to calculate poverty. Every thing is relative and statistics are only lies, to be used for convenience. Even while starvation deaths take place, to cover up the impact of human devaluing policies economists can show how the poverty line has gone down.

With that you can also see 'selective silence'. When it is convenient, they remain silent, they do not take a clear position. Let me give an example. After all the discussions about rational drug use in the World Health Assembly, there have been big discussions about compulsory licensing and parallel import of life-saving drugs. At a SEARO (South-East Regional Office of WHO) meeting, where all the delegates of South Eastern Asian countries were present, the agenda item of "access to medicines" came up for discussion and there was a complete silence. Everyone involved in the health, knows that prices of drugs have spi-ralled up. This is one of the reasons why public health systems are collapsing, because small institutions can not afford to buy the drugs and poor people cannot afford to buy the drugs. The States are

backing out from their financial commitments for health, so they are not buying enough medicines, even for the national health programmes. I had thought that our representatives, the delegates representing us, would speak about these issues. I had thought that if we put pressure on our democratically elected governments, they will raise their voice in the WHO health assembly because the Intellectual Property Rights (IPR) regime is not in the interest of the poor, but they did not say any thing.

There is another syndrome, that of the **selective amnesia**. You do not hear anyone talk about Alma Ata Charter any more. First, they had forgotten Alma Ata and had started to talk about selective primary health care. They said that only growth monitoring, oral rehydration, breast feeding, immunisation and family planning are important health issues. Then this phase passed and now they are all talking about fees for services, stakeholders dialogue, etc. When they say "the stakeholders", they are not talking about people and the communities. The national health policies and even the international aspirations about "health for all" have been forgotten.

Changing Scenarios

Global scenarios - free market, international trade regimes, unipolar world

National scenarios – countries debt burden

Health scenarios – more disease burden, vertical programs funded by World Bank

Increasing poverty, increase in number of poor, decreasing access to health, education, & food

Decreasing services

Let's us now look at the changing scenarios. As far as the poor are concerned, the forces against them are much bigger than before. **The global scenario** is dominated by the free market, international trade regime and a mind-set that markets will save the world. This kind of mind-set afflicts every one, especially the decision-makers.

Where the **national scenarios** are concerned, majority of the poor countries are crushed under the debt burden. For paying back the huge amounts of interests for the old loans, new loans are being taken from World Bank. The World Bank decides about the health priorities of countries and national governments have increasingly less voice about their own health needs. Thus the responsiveness from our national governments, which we could have expected at the national level, is not there, because the power lies some where else. During the 70s and 80s, we could talk to our policy makers, influence the policies, advocate and push for a comprehensive health care. Now we find that because of the new loans that they have taken, including a large number of new loans from the World Bank for the vertical health programmes, our governments have less power. The new loans come with certain conditions, which influence our national policy negatively.

As far as the **health scenario** is concerned, the disease burden is on the increase. According to the new WHO disease classification system, the diseases under ICD Z 59.5 (extreme poverty) are on the increase. The poverty-related diseases are on the increase, because extreme poverty is on the increase. Official responses to this situation is not through the optimisation of the resources, it is not through the comprehensive primary health care but it is

through the vertical programmes! So we have to consider the question of poor and excluded groups in this context.

Changing Scenarios – Voluntary Organisations

- Availability of funds is less
- Support is available for selective issues and not for comprehensive approach – why?
- Aid fatigue?
- Demand for performance indicators
- Change in paradigms towards economic growth, market driven, bio-medical approach based health

Changes are also taking place in the world of the **voluntary organisations**. For some of them, I feel very hesitant to use the word Non-governmental Organisations (NGOs) because in many places, corporate bodies and multinationals have also set-up their "NGOs". Thus, private interests, for-profit interests, service providers and non-profit volunteer organisations are all lumped together. How do you separate the non-profit organisations from these multinational "NGOs"?

The amount of funding available to NGOs has decreased. International funding now must go to Eastern Europe or it must go to different disasters and conflict areas while funds for development activities are less. Availability of funds for comprehensive primary health care, is much less. Support is available only for selective issues and vertical programmes.

Is it because of the **aid fatigue**? They say that poor people are not doing anything, they are only getting poorer. They say that the poor persons are not helping themselves. It is part of what I call, the victim blaming. Or is it that there is a change of paradigm and perspective that is taking place, even in the international NGOs?

At the same time, for any funding, the issue of **performance indicators** is becoming rigid and increasingly unrealistic. Funds can come if you are willing to say that maternal mortality will be reduced by this much and infant mortality will reduce that much. At the same time, people are not able to afford food, when 20% of the maternal mortality is due to anaemia and 85% of pregnant women are anaemic, how do you propose to reach these beautiful and unrealistic performance indicators only through selective and vertical approaches? These performance indicators focus only on the biomedical view of sickness.

Changing International Health Priorities

- HIV/AIDS, Reproductive Child Health (RCH), Adolescent Health, TB-DOTs, certain kinds of Research – are international priorities
- Organisations operating on ideals of faith, compassion and mission with genuine people's participation, are no longer fashionable and are changing

At the same time, there is also a change in the **international health priorities**. HIV/AIDS along with Reproductive Child Health (RCH) are both seen as international health priorities but in a very narrow sense not in a holistic sense. For example, both **Reproductive Child Health** and HIV/AIDS have something to do only with women? The men also have something to do with

these two priorities? The behaviour of both men and women has a lot to do with decisions about pregnancies, abortions, etc. When these become unsafe, many women lose their lives. So the response to these problems can not be building more abortion clinics, but it is also important to look at the reasons, which lead to the too many abortions and its effect on women's reproductive health. Should there be abortions for gender selection, as happens so often in our country? Should abortion be used as a substitute for the family planning? So often, they are being used as a substitute of family planning, so the trivialization of abortion is a big issue for us.

In some other countries, crimina-lization of abortion is a problem, because women do not have the choice. Women may have even 3 or 4 abortions of female foetuses, till they are sure that they are going to have a boy. This is demographic fundamentalism and is closely linked to sexual violence and oppression of women. Are these issues not linked to HIV/AIDS and Reproductive Child Health (RCH)? In the official RCH programmes, they do not talk about sexual violence, women issues, etc. For them, it is only family planning, safe motherhood, HIV/AIDS and safe abortion.

There is a lack of sensitivity in dealing with girls and women, who are victims of **sexual violence**. Even though they may have physical injury, unwanted pregnancy, infection with sexually transmissible diseases or HIV, be forced to undergo unsafe abortion or bear the effect of the violence psychologically for life, sexual violence is not part of the reproductive health programs.

The question of **infertility** is a big social issue. Women are deserted by their husbands because of infertility but it is not an issue for official Reproductive Child Health Programmes. We, persons involved in women's health, feel that the definitions given to official RCH programmes are inadequate because they do not keep account many important issues and have a very narrow focus.

Adolescent health is also becoming an international health priority. Suddenly they are worried about adolescent health, because increasingly adolescents are getting pregnant. In developing countries, young children and adolescents are a higher percentage of population compared to adults. But adolescent health is not just sexual health, just about safe sex and avoiding pregnancy. Adolescent health has to be seen with our own social-cultural context. It has also to deal with mechanisms of peer group pressures, issues like substance abuse and the changing social scenario.

Example of Tuberculosis (TB): TB is another international health priority. Where TB is concerned, there is a move towards internationalising of the health policies. This means promoting standard, inflexible regimes for the whole world. TB has to be treated with what is called Directly Observed Treatment (DOTs). But if the prices of the DOTs drugs are going to be so high and if these programmes are running with international loans from World Bank, how long are poor countries going to continue taking new loans, in spite of our already huge debt burdens? The loans come for 3-4 years of vertical programmes. In India only one-fifth of our districts are so far covered with the DOTs (it means access to be drugs is ensured). So our question is, what about the remaining districts? What about medium or long term plans, when the loans will be finished? It all seems to go with a very

myopic vision of intensive, short-term vertical programmes, without looking at the basic constraints like unaffordable drugs and collapsing public health.

The production of anti-TB drugs and accessibility of prices of anti-TB drugs are important for defining health strategies. Drugs like INH and Thiacetazone are now being produced less, because they are not part of the DOTs. When no new anti-TB drugs are on the horizon, is it wise to discard old well-known drugs? I am aware of the problems with skin reaction caused by Thiacetazone in some countries, where TB infection is linked to AIDS, but in situations where you don't have DOTs, should the patients be left without any drugs? Is it now DOTS or nothing?

On one hand, we say that we stand for rational TB care. On the other hand, if unhygienic conditions, which produce vulnerability to TB, are on the increase, if poverty is on the increase, if malnutrition is on the increase, then should the "rational TB care" still mean only DOTs? Why does no one speak about comprehensive TB care?

For certain kind of research, lot of funds are available. For example, there are lot of funds available for research related to sexual behaviours of different groups, often without sensitivity to the local context.

"Professionalisation" of NGOs: NGOs have taken over the mask of "professionalisation" from international donors and big multi-lateral agencies, so they also work for very specific areas with vertical approaches because they get money for that kind of work. They are very different from the organisations operating on ideals of faith and compassion, like those organisations, which have worked on leprosy. Mahatma Gandhi inspired many of them, many of them were and are mission institutions, who have given their lives for their work. For long years, they worked in a community, where they have seen certain gradual changes. They were completely different from these new "professional" organisations, which come for 2-3 years projects, if they find funds from a donor. As the fashions and whims of the donors change, they stop what ever they are doing and they start with something new. They work for girl-child projects for a few years because that is in vogue with the donors, then donors decide that they want to fund adolescent health, so they forget about girl-child and start adolescent health projects. If they work for AIDS then they are concerned only about those dying from AIDS and persons in the same community can die from starvation, diarrhoea, malaria, TB, dowry deaths, but they are not concerned, because it is not their "project".

Understanding the Silence – Reasons for Silence

No trust
No hope
Previous bad experiences – example, people interested in research but not in doing something, so people feel used/exploited, they never hear the results of the studies.
False promises in the past

The communities do speak, but who listens to their voices? They may also be articulating their concerns through the silence. It is up to us to understand this silence. Especially the women, when they are in a group, they may not speak. Silence may mean that there is no trust, or it may mean that there is no hope. They may feel that so many people have tried to change the world and to deal with different issues

without any success, so that there is a deep rooted sense of hopelessness. There are all kinds of persons coming and promising to the communities, making big speeches about the suffering humanity, and in spite of all the promises, the people continue to suffer. This is especially true of political parties coming to the communities.

Changing Nature of Listeners

- Private consultancy firms collecting data
- Industries and corporations are entering the development programs
- Move towards Local self-Governance
- Conflict between:
  - We will give you free medical care & education
  - We will help you to organise to meet your own needs and access to what is your right

Nature of Listeners: However, there are so many kinds of groups coming to "listen" to the communities. Like the private consultancy firms all over the rural areas. Like the drug companies wanting to know from the community how they are treating different diseases. Like the persons interested in learning about local traditional healing systems. We have started to discover all these different groups with their different motives, suddenly interested in the "voices" of the communities. We are one billion persons in India and we have more than 200 million strong middle-class, who represent a "market". So the different private consultancy firms come and ask all kinds of questions and communities become hunting grounds. They are hunting for institutions like hospitals and their questions may be linked to ideas of promoting private insurance. Investment for private health sector is encouraged. So industries and multi-nationals are entering the "development programmes". Many different companies have now funds for some "community health and development programmes".

In India, according to our constitution we have local self-governance of the communities through "Panchayats" (village councils). This means that elected persons from the village will form part of the village council and 33% of the seats of the council are reserved for women. This seems a good step and every one hopes that there will be decentralisation of decision making at the village council level. But the powers of these councils are very limited. Often, they do not know about their own powers, as there is not sufficient support and capacity building of the village council members. So they do not know the decision making process and the importance of their decisions. So who is the real representative of the community here – the village council members, who have been elected by the villagers or the NGOs, which say that they are working for the people and represent people's voices? To whom do communities speak? Poor persons in the community will go to those that they feel will listen to them.

How can you promote development in this situation where on one hand, a group may be promoting self-reliance and development through their own efforts and on the other, you have a group, coming with money to provide free medical care and free education? Naturally, the communities get confused in such a situation.

Expressed Priority Needs of the Poor

- Food, water, work, livelihood, fair wages, safety for women, transport...
- Health and education are much lower in hierarchy of priorities – ask for hospital doctor, lady doctor for women, English medium or good schools
- NGOs becoming willing partners of top-down vertical health programs – different from community priorities

Expressed Priority Needs of the Poor: In most of the places, the expressed priority needs of the communities include food, water, work, livelihood, fair wages, safety for women, transport, etc. Education and health issues usually come much later in these priorities. Most of the health groups are not in a position to help the communities with those other priorities and they focus only on the health-related needs. To answer such specific questions, communities usually answer that they need a new doctor or a lady doctor for the women or a new hospital. If you talk to them about community health services, preventive medicine and self-reliance, they are not very interested because other 'corporate NGOs' are willing to provide such medical solutions. So wherever communities health programs were initiated in 70s and 80s, like in Latin America, Central America, Philippines, etc., it was much easier, because they did not have all these private sector entities coming in the villages in this way.

Even when you talk of basic education, even in villages where, there is no primary school, the communities ask for English-teaching good school, because they think that going to such schools will help their children to get jobs later on.

NGOs today are becoming willing partners of top-down vertical health programs, which are very different from community priorities. When there was a severe malaria Falciparum outbreak in Rajasthan in India, family planning camps were being organised. When there was a big malaria outbreak in Assam in India, such seminars on HIV/AIDS were being organised. I do not say that you should not organise family planning or AIDS/HIV related activities, but if community needs an urgent intervention, you can not close your eyes and go on doing your own vertical programmes.

Dilemmas of NGOs – Unable to Answer Priority Needs of the Poor What to do?

- **Listen with empathy**
- **Listening & acting by providing critical informa-tion**, documents, contacts, links...
- **Joining the poor** for moral support and solidarity exam-ple, anti-globalisation protests, Food Rights Campaign
- **Public interest litigation** – going to the Courts/Tribunals to fight for rights
- **Advocacy** – **A**. Sensitising those who can help poor; **B**. Those who need to change attitudes like on gender issues
- **Training with critical awareness** – people's education for health action
- **Providing services** for Malaria and vector-born diseases, Tuberculosis, mother & Child health, Reproductive child health, primary health care, etc.

Role of NGOs as Listeners: As NGOs, we are not always free to do what we wish, even if we know the urgent needs and priorities of the communities where we work. Some times, we find ourselves in a dilemma because of this. However even in such situations we can be respectful to the communities.

At least, we can listen with empathy instead of saying that no, we only deal with health care. Even giving time to listen to and to understand the issues can be a contribution. Listening and supporting by providing critical information and providing documents, contacts, links etc. to the communities so that they are able to take action, can be invaluable. We can join the poor for moral support, for example in initiatives like Narmada dam protest, anti-globalisation protests, Food Rights Campaign etc. We can help them through Public interest litigation – which means, going to the Courts/Tribunals to fight for rights of the marginalised groups. We can help through advocacy by sensitising those who can help the poor and by helping in change of attitude of decision makers. We can also providing services for malaria and vector-born diseases, tuberculosis, mother & Child health, reproductive child health, primary health care, etc.

Other efforts have been made for advocacy that means, sensitising those who can help the poor, including some judges and parliamentarians. It is important to be able to identify potential allies in decision-making roles, to inform them about the issues, and to help them to interact with the communities and with poor groups.

Another important target group for sensitisation is that of health personnel. Some efforts have been made to bring a change in the medical education. In our medical colleges, we are not taught women's health, we are not taught mental health, we are not taught social roots of mental health problems etc. We are taught about theories of Freud, Jung, etc. and then we realise that social cultural context of our mental health problems is so different from some of these theories. For example, a study of the NIMHANS (national institute of mental health) has shown that for neurosis, the traditional health systems in India can be much more effective than western-medicine based hospitals and the patients are much more responsive.

COMMUNITY HEALTH CELL ★ Chennai 600 011

NGOs can also support through training with critical awareness – for example, people's education for health action. Like the five booklets that are part of the People Health Assembly - these deal with different issues liked to primary health care and the Alma Ata declaration including commercialisation of health care, and what globalisation does to people's health, the issues related women, elderly and disabled persons, etc. These booklets have been translated to several regional languages. People working in the field understand some of these issues now, because of the discussions and debates within the people and health movements but if you talk to medical doctors, or even post graduate specialists, often they have never heard about it. They do not know what is WTO, and how does it influence health. So there are gaps in mainstream medical institutions. This is critical information and building the capacity of communities and these specific groups so that they are able to analyse the issues and are able to make choices is very important. ■

The Voices of Disabled Persons

Claudio Imprudente

I am going to tell you about our project called "The Inkpot".

I want to tell you about this project. How did we come to this idea? We started by reflecting about the word "disabled". What does it mean, "disabled"? It means "unable to do something". So we start from a negative picture. If a person is unable, then can you have confidence in such a person? Obviously no. This means we have to be aware of this cultural view, which looks at disabled persons as inferior to non-disabled persons. We need to change this cultural view, but how do you do that? Very simply, I think that we have to start from self-awareness in disabled persons so that they are aware about their own potential and capabilities.

For me, disability is not something negative, it is something enriching. You have to change the perspective through which, you look at the issues.

You may be asking yourself, how am I communicating, if I am not speaking? Have you understood my way of communication? I look at the alphabets on this transparent board and Roberto, sitting on the other side can follow my eye movements, and read out to you my words. I am not disable for reading in this way, I am only doing things differently. This simple way of communication is a cultural revolution.

To make this concept understand to the children, I and other disabled persons from our association, we visit schools and interact with school children. Children will be the adults of tomorrow and they must be educated to look at diversity as cultural richness, as a resource and not as a misfortune. By changing the point of view, a disabled person becomes a differently able person. We must emphasise the ability and not the disability. If do not speak, then it is a disability but I find this simple way of communicating then I am only speaking differently, so I am differently able.

This is a revolutionary concept because I am not an object of treatment or assistance, but I am active subject of the culture. Sometimes, they invite me to the meetings of the associations of the sick persons, so you what do I do? I take a thermometer and measure my temperature. If I have fever, obviously I do not go, and if I do not have fever, I do not go as I am not sick any way. This is to explain that often persons equate disability with an illness. **Disability and illness** are two different things. I am all right, I just have an impairment, from which my disablement comes. However, **impairment and disability** are two different things and these should not be mixed together. I may continue to have my impairment, but my disability can change. For example, if I have the wheel chair, I can move around. A large door decreases my disability, as I can enter with my wheel chair, a ramp in front of the cinema hall decreases my disability, if people have confidence in me, it decreases my disability. However, lack of confidence in my abilities and barriers like the stairs, increase my disability.

So having confidence of the others is very important for me. In my own life, I have received lot of confidence, thus I can also give my confidence to others, and from confidence starts more confidence. If I can share my experience, if I can show my confidence in others, slowly we create a culture of confidence.

Let me conclude by talking about **visibility**. Usually, you do not see the differently abled persons. They are not visible, because they remain hidden. For example, you do not see them in the television. I believe very firmly that we have to be visible, because it is important for our political role, to do advocacy, to put pressure on policy makers. Some times, I have gone to the television programmes because I believe that we must be more visible.

Similarly, if this workshop is talking about poverty and poor persons, who remain invisible, no one is going to know about it. When we talk of poverty, we also need to talk about making poverty visible, making poor persons visible. If it remains hidden, it is only a weakness, only when it becomes visible then it becomes strength for a change. ■

Understanding & listening to the Voices of the Poor
Group Discussions

Power Relationships and the Poor:

Money is a fundamental issue in the power relationships, obviously who has more funds and access to it, has more power. Credibility in the long term is another central issue in the power relationships. It is important to look at information and knowledge issues. Without access to information and without knowledge, it is not possible to have power. Apart from knowledge, the possibility of managing legal instruments is also important. Such legal instruments are there at times but capacity to manage these is required.

Visibility is another central issue because it gives political weight and without visibility, it is as if you do not exist. Power is also linked to exercise of authority. For example, male-female power issues are also linked with authority.

Looking together at all these different factors related to power, it seems difficult that the excluded groups, the poorest groups, the differently able persons have access to these factors and so it is going to be very difficult for these groups to have any power.

In CBR programmes, some times the technical consultants do not understand the concept of CBR or the concept of sustainable development, so the power-issue becomes important. In the training of grassroots workers and in promoting the role of community, some times experts and funders force their ideals and plans as part of their "facilitation".

Foreign Experts and the Poor:

The excluded and poor population groups have their own cultural richness and it is difficult for the expatriates and foreign experts to listen to the poorest and to understand their voices. It is difficult because the poor are an uncomfortable reality for expatriates, they represent the diversity and they force the expatriates to look at issues from different point of views.

Expatriates often create confusion between culture and the quantity of notions, so that one can come to a conclusion that there is nothing to be learned from the poor and the excluded groups. This is a major hurdle in understanding.

Communities have the skills and have the knowledge but it is not visible or understandable to outsiders, so community organisation may be needed to strengthen these skills and to make them understandable. The whole concept of self-help and empowerment plays a key role as an outsider health worker can suggest pills and treatment for an ailment, but persons themselves decide if they want to actually take those pills or treatment.

Helpers and Receivers:

Another significant problem is the disparity, intended as superiority, intentional or unintentional, between those receive "help" and those who give, because it means that one is "good" and the other is "unfortunate". This disparity makes it difficult for experts and expatriates to listen to and to understand the voices of the poor.

Strategies:

It could be useful to create a network of listening and sharing through the communication technologies, like it happens in the developed world. Such communication means are not always present in poor communities and when they are present, they are very simple. It is important to create this network, where information must circulate, going outwards and coming backwards for a feedback as information is the basis of knowledge and power. Often there are different actors in an area like different associations, workers unions, groups of disabled persons, religious groups, etc., but they sometimes have difficulty to work in network and to inform each other. If each group thinks only about its own sphere then there is risk of wasting part of this energy.

It is not only knowledge or information, necessary for empowerment of the marginalised groups but they also require skills, skills that are essential for sustainable development. Skills, attitudes and knowledge, all play an important role in empowerment.

The different occasions of meetings that are there in all communities need to be encouraged and there must be such occasions where communities can speak to each other, share information and make proposals. In the developed world there are such opportunities between service providers and associations of clients like the meetings between hospital professionals and patient groups to discuss the problems and to find common solutions. There are also courts, which look after the interests of the patients if there is need.

It is important to identify key figures among the poor groups, who can be spokespersons for them and who can explain their point of views. If the key persons are the right persons, it would make every thing else much simpler and effective.

It is important to sustain the programmes through the participatory approach, but there can be other approaches, which are also needed, like the relief approach, which is needed in crises like earthquakes and cyclones, etc. Fixing the targets is a very tricky issue. Many government programmes fix the targets because they have to finish their budget and they must complete the target by the end of the financial year. So some times, they are worried only about official reports and target reporting, without really worrying if the benefits or the facilities reached the needy people.

Excluded population groups, they have a knowledge and experience of their own, which is not facilitated by the outsider, it is part of their own lives. However, outsiders can play a vital role in making sense of their own experiences, see them in relation to outside factors and for a global understanding of the causes. For this, it is important that facilitators and project managers are trained in participatory methodologies and they use these similar methodologies in dealing with the communities. In this regard, training of the grassroots workers is fundamental because they play a very important role in linking with the communities. They can be the catalysts and they can create the links between the peripheries and central management of the project. ■

Voices of Participants

Geraldine Mason-Halls/Guyana

Being creative in the development of systems at the community and other levels, is to facilitate a process which enables the voices of the poor to be heard. Mechanisms must be built into these systems to ensure that the poor also have the possibility to hear and be aware of the views of government, public sector. This can give rise to a dynamic relationship for change in the lives of the poor and voiceless.

Sunita Zacharia/India

We need to look at the community's needs. We need to remove the blinkers or the pre-set agenda, we (as organisation) have and thrust upon the community.

Poverty, Development and Health

FINAL DOCUMENT

PART I
GENERAL BACKGROUND

Objectives of the Workshop:

Keeping in mind the present global context, the main objectives of the workshop were as follows:

- To understand the nature of poverty and vulnerability
- To understand, who are the poorest and more vulnerable persons today
- To understand their difficulties of access to different services, especially health services
- To Understand the ways for listening to the voices of the poorest and more vulnerable groups
- To identify the challenges and opportunities for advocacy for improving the lives of the poorest and vulnerable persons
- To provide an opportunity for persons working for and with poor and vulnerable populations for networking and exchanging knowledge and experiences

Participants:

The workshop involved project managers, representatives of non-governmental organisations, expatriate volunteers and persons with long experience of working along with poor and vulnerable populations from the following countries –

Asia:	China, India, Indonesia, Mongolia, Nepal, Pakistan and Philippines.
Africa:	Angola, Comores, Con-go, Ghana, Liberia, Mozambique and Zimbabwe
S. America:	Bolivia, Brazil and Guyana
Europe:	Italy and Spain
N. America:	USA

Methodology:

The workshop was organised in sessions of keynote presentations and group discussions on three main themes:

Poverty – Who are the poor and criteria for identifying them
Equity and access to services, especially health services
Listening and understanding the voice of the poor

PART II
WORKSHOP CONCLUSIONS

Poverty And Vulnerability:

Poverty is not related only to economic aspect but it is multi-dimensional. It is related to powerlessness, to not being counted, to not being considered, to be excluded, to be unheard. Poverty is related to exploitation, oppression, victimisation and violence. It is also related to migration, forced displacement, rising urbanisation, loss of livelihoods.

Poor are excluded from productive processes, are unaware about their own rights and duties, lack self-confidence and lose their cultural identity. Poverty is in lack

of choice, instability and violence forcing people to lose homes, livelihoods and belongings to become migrants, displaced and refugees.

Among the poor, the more vulnerable are those who are dependent and who have no say in decisions regarding their lives. These include women, disabled persons, minorities (ethnic, religious or linguistic), refugees, old persons without families, illegal emigrants, shelter-less and street dwellers, landless peasants, persons associated with disease conditions like leprosy, tuberculosis, AIDS, etc.

Social and cultural traditions can worsen the conditions of specific groups like persons belonging to lower castes in certain parts of South Asia, children victims of sexual and labour exploitation, widows, single mothers, uneducated persons, wives of alcoholics, bonded (slave) labours, prisoners, etc.

Criteria for measuring poverty and identifying the most vulnerable groups, need to be adapted to each single context. Poor have limited access to food, water, information and services like education and health. In rural contexts, the materials and services are less available while it is relatively easier to organise communities. In urban contexts, the material and service availability is better but there are difficulties of access to these by the poor, while there are additional problems of over-crowding, violence, crime and substance abuse. In urban contexts, it may be more difficult to organise communities.

In both rural and urban contexts, the rights of the poor and powerless are negated, while economic-alimentary equilibrium is very fragile and there is increased vulnerability to infections, ill health and disability.

Impact Of Changing Global Context:

Domination of free market economic philosophy based on maximising the profits for those with power, worsening of ecological situation, growing power of multinational corporations, weakening of national and local decision making and weakening leadership roles for international organisations like United Nations, World Health Organisation, etc. as well as for national governments in developing countries, are some of the characteristics of the present global context. At the same time, the power of international financial organisations like World Bank, International Monetary Fund and World Trade Organisation, who have assumed a major role in deciding national policies for reducing national budgets for health, education and social services, forcing structural adjustment programmes requiring privatisation, promotion of vertical programmes and "services for those who can pay" philosophy. These changes have seen an increase in the number of the poor, making new poor and worsening the lives of the poor, decreasing their access to services.

As far as voluntary organisations are concerned, availability of funds, especially for promoting comprehensive and integrated development programmes, has decreased. New organisations, consultancy firms and foundations created by multinational and trans-national corporations, have appeared, promoting specific single agenda vertical programmes for their own image-building.

The funding is usually for limited periods, focussing on specific activities, without considerations about comprehensive health needs of vulnerable target groups or sustainability, accompanied by unrealistic performance targets, promoting universal standard recipes without an understanding

of local needs or situations. As far as health services are concerned, while role of World Health Organisation is Marginalised, organisations like World Bank have become the major players for funding vertical single-agenda vertical programmes and research activities.

In the developing countries, the multinational corporations and international financial institutions find willing partners among some civil society representatives like politicians and institutions, interested in short term gains. Representatives of organisations and institutions working for the poor and oppressed, challenging the policies and practices, which worsen the lives of the poor, can face harassment, detention, violence and even death.

At the same time, the new instruments and technologies of communication, can give an opportunity for raising consciousness and organisation of poor communities for influencing their own lives and the collective lives of their communities as well as for a political change. Individuals and organisations from both, South and North of the world, can promote advocacy action to raise voice and create awareness about negative impact of globalisation, such as the People's Health Movement.

Equity and access to services, especially health services:

Health has different dimensions – physiological, spiritual, physical, mental, social and cultural. It is a result of interplay between individuals and their environments. Health resides inside the persons, the primary units of a health system. Health requires awareness about basic human rights and the possibility to influence changes in the health service system so that they respond to the basic health needs of the people. Health requires participation of the different stakeholders including community members, traditional healers, traditional birth attendants, health workers, local artists, local community leaders, etc.

Health does not reside inside the walls of buildings of health structures – inside these structures reside the pharmaceutical industries and curative health care, which dominate and marginalise critical health action, health information and preventive care.

Most of the national health budgets go to high technology institutions catering to the needs of limited number of citizens while primary and community health services receive a small percentage of available limited resources. Primary and community health services may be inaccessible due to long distances, lack of or high cost of transport, lack of qualified personnel, high fees of the services, etc. The health personnel may work with very low salaries, in some situations unpaid for long periods, facilitated for working with vertical programmes promoted by international organisations through payment of incentives and per-diems. Often, the pharmaceutical industries promote unnecessary drugs and their combinations, while ignoring the "unprofitable" essential drugs.

To improve the access of the poor and marginalised groups to the health services, organisation of the communities and information about disease prevention is necessary, so that communities can fight against factors influencing negatively on the harmony between individuals and their environments. While the health personnel needs training, community members also need training. The organisations of the health services must involve the beneficiary communities in the decision-making

process. Preventive medicine and traditional medicine need to be given more importance. At the same time, organisations working with poor communities need to network, share ideas and information, working together to ensure equal access for different disadvantaged groups like women, children and persons with disabilities.

Listening And Understanding The Voices Of The Poor:

The poor do not have power. The power is linked to access to information and skills, access to funds, visibility and political strength. It is also linked to brute force, like the men-women relationships, often with the approval of traditions, culture and social support systems. Managers, administrators, donors have more power the clients.

It is difficult to listen to voices of the poor, since their knowledge and skills are not seen as useful or important. Project managers and donors feel that they know the problems and the best solutions. The poor may not be articulate or may not speak the language spoken by project managers and donors. Project managers and donors do not have the time to stop or visit or understand the living environments of the poorest. There are cultural barriers to listening to the poor, who are seen as ignorant and uneducated.

Real development and transformation comes only if project managers and donors can listen to their clients and discuss their own ideas with them. Once the community is transformed, they will become the subjects of their own development. It is not enough to visit the poor in their living realities but project managers and donors need to live with them to understand their concerns and ideas. Facilitating the communities to organise themselves through activities like Self-help Groups (SHG) can be useful.

Project proposals can not be developed simply from good intentions and ingenuity, for this preparatory work in the communities is necessary and skills of project managers are needed, who need to play the role of catalysts. Networking and horizontal exchange of information between self-help groups and community-based organisations is essential for their capacity building. Identifying and involving community leaders is an important part of reaching the communities.

There may be areas linked to traditions, cultures and social ethos of the communities, with which project managers and donors may not agree. Changes in such areas can come only through involvement and empowerment of oppressed groups and victims, who need to become the protagonists for a social change.

Participants in the Workshop

Angola: Jean Pierre Brechet, Sr Dionisia Kandeia.

Brazil: Cristina Firmo, Deolinda Bitencourt de Santana, Eduardo Manzano, Eliana de Paula Santos, Eugenio Scannavino, Fernando Corso, Fr Joao Lopes, Heloisa Manzano, Joachim Ribiero, Lidiane Aparecida da Silva, Max Robson, Pio Campo.

Bolivia: Elisabeth Osorio, Alicia Limachi.

China: Michael Chen.

Comores Islands: Saverio Grillone.

Democratic Republic of Congo: Chiara Castellani.

Ghana: Fr George Abram.

Guyana: Geraldine Mason Halls.

India: Bharati Mohanbabu, Cresentia Toppo, Daisy Kandathil, Dorte Chorei, Javed Abidi, Jayanth Kumar, Jose Manikkathan, Joseph John Alexander, Maya Thomas, Mira Shiva, Sunita Zacharia, Usha Nayar.

Indonesia: Nurshanty Andi Sapada, Suriah Tjegge.

Italy: Alberto Porro, Antonio Landolfi, Claudio Imprudente, Enrico Barchi, Enzo Zecchini, Federica Zecchini, Felicita Veluri, Francesca Ortali, Franco Macera, Giovanni Gazzoli, Lorenzo Carraro, Luca Bellina, Luigi Gravina, Massimo Abate, Michela Di Gennaro, Paolo Franco, Raffaella Liuti, Roberta Giacobino, Renato Blangero, Roberto Ghezzo, Roberto Giorgetti, Salvatore Noto, Simona Venturoli, Simonetta Viviani, Sunil Deepak, Susanna Bernoldi.

Liberia: Lemuele Boah.

Mozambique: Massimo Tomaselli.

Mongolia: Damdinsuren Tulgamma.

Nepal: Sarmila Shrestha.

Pakistan: Farhat Rehman.

Philippines: Fr Norberto Carcellar.

Spain: Maria Estremiana.

Vietnam: Lorenzo Pierdomenico.

USA: Mathew Maury.

Workshop Programme Summary

Day 1: 26 October, 2001
09.30 Inauguration
10.30 Coffee break
11.00 Presentation of the workshop – Introduction to Participants (Sunil Deepak)
12.30 Lunch Break
14.00 General Context – Poverty & Development (Mira Shiva)
15.00 Coffee Break
15.30 Identifying the poor and strategies for reaching them (Usha Nayar)
16.30 Poster Session – 1
17.30 Conclusion of the day

Day 2: 27 October 2001
09.00 Field experience related to identifying and reaching the poor (Maya Thomas)
09.45 Group Discussions
10.30 Coffee Break
11.00 Group Discussions
12.30 Lunch Break
14.00 Plenary Presentations of groups
15.30 Coffee break
16.00 Poster Session –2
17.00 Dance-therapy session (Pio Campo)
21.00 Social Evening – Dance, Songs & Music from different countries

Day 3: 28 October 2001
09.00 Equity & Access to health and social services (Chiara Castellani)
09.30 Field experience for difficulties in access to services (Eugenio Scannavino)
10.00 Group Discussions (Coffee break at 10.30)
12.30 Lunch Break
14.00 Plenary Session
15.00 Coffee Break
15.30 Listening & Understanding the voice of the poor (Mira Shiva)
16.30 Poster Session –3
17.30 Dance Therapy Session (Pio Campo)

Day 4: 29 October 2001
08.30 Listening and understanding others (Claudio Imprudente)
09.00 Field Experience – difficulties of access for poor (Javed Abidi)
09.30 Group Discussions (with Coffee break at 10.30)
12.30 Lunch Break
14.00 Visit to AIFO Office in Bologna
Visit to Centre of Bologna - Guided Tour, Reception at the Municipality of Bologna,

Day 5: 30 October 2001
09.30 Plenary session for group presentations
10.30 Coffee Break
11.00 A Final Document for the Workshop – discussions in Plenary
12.30 Lunch Break
14.00 Presenting the final document – and its approval by participants
15.00 Coffee Break
15.30 Workshop Assessment

Conclusions and Formal Closure

Part II

Equal Opportunities for All: Promoting Community-Based Rehabilitation (CBR) among Urban Poor Populations

FINAL DOCUMENT

A Joint Initiative between Disability & Rehabilitation team of WHO (WHO/DAR) and AIFO/Italy

Foreword

The WHO Disability and Rehabilitation (WHO/DAR) Team and the Italian Association Amici di Raoul Follereau (AIFO) are happy to present this document entitled *Equal Opportunities for All: Promoting Community-Based Rehabilitation (CBR) among Urban Poor Populations*.

Over the last 20 years, WHO has gained considerable experience in developing and implementing CBR with and for persons with disabilities. However, most of the experience of CBR has derived from rural areas in developing countries. At the same time, we are keenly aware that even in large metropolitan cities specific population groups, such as persons living in slums and in low-income areas in urban peripheries, may also face difficulties in accessing the available rehabilitation services.

For this reason, representatives of organisations working in urban slum and low-income areas were invited to a consultation in Manila (Philippines) in September 1995. As a result of this consultation, basic guidelines on implementing CBR in urban slum and low-income areas were prepared.

The strategies defined in Manila in 1995 were implemented through a joint collaboration between WHO/DAR and AIFO from 1996 until 2001, whereby pilot projects in various parts of the world were set up. During this period, the centres participating in the initiative visited each other and met periodically to reflect on their experiences, and to share ideas and information about their successes and constraints.

In October 2001, representatives of the pilot projects assembled in Bologna (Italy) for a final meeting and to prepare a report on the implementation of CBR in urban slum and low-income areas. This report also presents glimpses of the journey made by the participants of the initiative — in discovering and learning about each other's work.

As a result of these projects a guide for Rehabilitation in Primary Health Care entitled *Promoting Independence of People with Disabilities due to Mental Disorders* was published in collaboration with the Mental Disorders Control Unit, Division of Mental Health and Prevention of Substance Abuse, and the WHO Regional Office for South-East Asia. The Division of Mental Health and Prevention of Substance Abuse also provided training for people in urban slums in Kenya.

We should like to thank all persons from the slum and low-income communities and the organisations working there for giving their time and energy to this initiative, and for making it a success. Thanks are also extended to DAR donors and, in particular, the governments of Italy, Norway and Sweden as well as institutions and individuals who have provided support.

Dr Enrico Pupulin
Coordinator
Disability and Rehabilitation Team
World Health Organisation

Dr Enzo Venza
President
Italian Association Amici
di Raoul Follereau

27 June 2002

Equal Opportunities for All: Promoting Community-Based Rehabilitation (CBR) among Urban Poor Populations

FINAL DOCUMENT

INTRODUCTION:

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BACKGROUND

General

At a global level, 7–10% of the population is estimated to be disabled. A large number of disabled persons, especially in the developing world, have no access to institutional rehabilitation services that are usually based in big cities with a limited service capacity.

The concept of community-based rehabilitation (CBR) was proposed by the World Health Organisation (WHO) in the late 1970s to increase the coverage of rehabilitation services for disabled persons. Initially it focused on medical and functional aspects of rehabilitation needs. Soon afterwards

other agencies of the United Nations, United Nations Organisation for Educational, Scientific and Cultural Development (UNESCO) and International Labour Organisation (ILO) proposed similar approaches for dealing with the educational and occupational aspects of rehabilitation. Implementations of field activities based on this approach, which values existing resources, skills and capacities in the families and communities, were known as the "WHO Model", "UNESCO Model" and "ILO Model" of CBR.

Gradually it became clear that, for CBR to be effective, disabled persons require a multisectoral approach that covers all aspects of life. It was also evident that these activities related to medical, social, psychological, educational and occupational aspects have limited impact on the lives of persons with disabilities and their families unless attitudes change in the communities, unless there are effective national policies and laws which guarantee equal opportunities to all citizens, and unless persons with disability themselves have the possibility of making choices and are empowered to take decisions concerning their own lives.

This evolution in the concept of CBR resulted in a collaboration involving WHO, UNESCO and ILO in 1994. A paper entitled *Joint Position Paper on CBR* ensued, which attempted to go beyond the different "models". It defines CBR as:

> *...a strategy within general community development for rehabilitation, equalisation of opportunities and social inclusion of all children and adults with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational and social services.*

The present document, *Equal Opportunities for All: Promoting Community-Based Rehabilitation (CBR) among Urban Poor Populations*, proposes general guidelines for initiating and sustaining the CBR approach in urban slum and low-income areas. The document is based on experience of working in urban slum and low-income areas in several countries.

CBR in urban poor communities and slums

In the last two decades, efforts for promoting and implementing CBR programmes have concentrated mainly on rural areas. At the same time, it has been recognised that disabled persons living in slums and low-income areas in urban settings do not have full access to the existing rehabilitation services. Keeping this in mind, in September 1995 the Rehabilitation Unit of WHO, which is now named the Disability and Rehabilitation (DAR) Team, organised an international consultation in Manila (Philippines) on the feasibility of implementing CBR in urban poor communities and slums.

Representatives of ten organisations involved in community development activities in urban poor communities and slums were invited to this consultation. The participants agreed that integration of the CBR approach into their existing activities was feasible if the activities were targeted at specific vulnerable groups, including persons with impairments, street children, single mothers, drug and substance abusers, etc. As a result of the consultation, a report was prepared entitled *Equal Opportunities for All: A Community Rehabilitation Project for Slums*.

Based on this document, the ten organisations were invited to elaborate proposals for projects, which could be submitted to the WHO/DAR for support.
It was decided that these projects would be used as pilot case studies to verify the applicability of the ideas discussed in Manila to field conditions and that, after a iimited period, the project implementers would be invited to meet for a second consultation in order to review and finalise a strategic document on initiating and sustaining the CBR approach in urban slum and low-income populations.

Projects participating in the initiative

Five of the ten organisations that participated in the Manila consultation in 1995 presented a project proposal, which was approved by WHO/DAR, and support was provided to initiate these pilot case studies. An Italian Association Amici di Raoul Follereau (AIFO), which was already collaborating with WHO/DAR for implementation of CBR programmes, became a partner of WHO/DAR so that the projects could be followed, monitored and facilitated.

Three additional projects not deriving from the Manila consultation joined the initiative at a later stage. Thus, a total of eight projects have participated in this initiative and are located in the following cities:

Alexandria, Egypt
La Paz, Bolivia
Makassar (Ujung Pandang), South Sulawesi, Indonesia
Mumbai, Maharashtra, India
Nairobi, Kenya
Quezon City, Philippines
Salvador, Bahia, Brazil
Santarem, Para, Brazil

Among these eight projects, two (Egypt and Indonesia) have direct governmental involvement through personnel working for ministries of health, while the others are supported and managed by national nongovern-mental organisations (NGOs) and grass-roots organisations (GROs), though they also collaborate with governmental structures in different ways. In some projects such as the ones in Santarem (Brazil) and Nairobi (Kenya), a number of NGOs and GROs are involved, working together in formal or informal networks. In the Santarem (Brazil) project, government departments such as prison services, municipal authorities, etc., are also involved. Finally, the project in La Paz (Bolivia) is managed by a disabled people's organisation (DPO).

Methodology of the pilot case studies in the field projects

From the experience gained in implementing the CBR approach in urban poor communities and slums, it was decided to promote continuous exchange of experience and reflection through four main instruments — preparation of six-monthly activities reports that highlight the difficulties encountered and choices made for overcoming them; exchange of experiences through a newsletter called *Sharing*; project verification visits; and organisation of exchange visits between the projects.

In October 1998, members of several projects participating in the initiative met in Bologna (Italy) to reflect on the early difficulties and methodologies of initiating the projects. During this meeting they also interacted with other project implementers who were involved in promoting community development, health care and CBR activities in various parts of the world in differing situations such as rural communities and refugee camps, etc.

Two project exchange visits were arranged: the first one in November 1999 to Salvador (Brazil) and the second in November 2000 to Mumbai (India).

A concluding consultation of representatives of the participating projects was then organised in Bologna (Italy) from 22 to 24 October 2001. It was held jointly by WHO/DAR and AIFO, with the objective of finalising a strategic document to implement the CBR approach in urban poor communities and slums. The present document is a result of this consultation. Though it is recognised that promoting CBR in urban low-income and slum areas would include activities related to several vulnerable groups, the present document concerns itself mainly with issues related to disability.

STRATEGIES FOR IMPLEMENTING CBR IN URBAN POOR COMMUNITIES AND SLUMS

The urban poor and slum dwellers

Past decades have seen a gradual increase in disorderly and informally occupied urban areas, a result of rural–urban migration and displacement of poor population groups in search of livelihoods and survival. These urban areas are known as slums, favelas or bidonville and they are characterised by the following factors:

High population density and lack of proper housing: Large numbers of persons are forced to live together in small spaces. For a majority of poor persons living there, the living spaces may be precarious structures made of mud, tin sheets or plastic, etc.

Changing dimensions and security: Some of these areas may be relatively new and constantly threatened by bulldozers. Others may be of a much longer duration, even decades, constantly enlarging with the arrival of new persons. Occasionally the civic authorities may even legalise some areas.

Poverty: Though the majority of the inhabitants are poor, unemployed or employed as wage earners or labourers in informal sectors, some persons may be relatively better off in certain long-standing areas.

Services: Many of these areas do not have access to public services such as electricity, roads, hygienic services, drinking water, health care, education, etc.

Mobility: Some inhabitants, especially in long-standing areas, may be relatively stable while others are more mobile, forced to search for alternative places or to come to the urban areas for seasonal work. Persons living in long-standing areas may have been born and raised there.

Ethnic, religious and linguistic differences: In some of these areas, the inhabitants may belong to different ethnic, religious or linguistic groups characterised by occasional conflicts.

Persons living as squatters are often unaware of their collective numbers and identity. They may face the obstacles of the city as individuals or as family units, without any knowledge about their rights as citizens. Persons living in slums, especially those who have been there for some time, could be made more aware of their collective strength and needs.

Many need to cope with alien surroundings, different languages, cultures, ethnic origins and religions, etc. The lack of traditional support mechanisms of village communities makes them more vulnerable to exploitation

and oppression. Sometimes, it is the men who come to cities for work and leave their families behind in the villages. For survival, whole families including children may need to work or older children may need to take care of the younger siblings. Even when families realise the importance of education, their children may not have access to education because of the shortage of schools in the neighbourhood, because of teachers' attitudes or because of bureaucratic difficulties such as the lack of children's birth certificates.

Other problems resulting from this situation include violence, drug and substance abuse, prostitution, street children, etc. Lack of hygiene and basic health services may lead to higher risks of infections, ill health and disabilities with high rates of morbidity and mortality. Violence, especially towards vulnerable groups such as persons with disability, can be a serious problem.

Given all these conditions, it is difficult to visualise a "community" among the urban poor and slum dwellers. However, family members, friends, neighbours and concerned persons in the low-income and slum areas can constitute a first level of "community". In addition, in long-standing slum areas there may be persons who are recognised as leaders because of their political, civic or religious role. There may be organisations or informal groups of women and/or youths in the slums and urban poor areas. Although slum dwellers are usually seen as "receivers" of aid, they may still have their own resources and a willingness to help others who are even more vulnerable.

Initiating CBR

Concerned parents or local grass-roots groups can initiate a CBR programme in an urban poor area or slum. Sometimes it may require the intervention of external facilitating agencies, which could be governmental authorities or local nongovernmental organisations.

Before any such programme starts, the communities need to have some familiarity with and confidence in the persons belonging to the initiating agencies. At the same time it is essential for the initiating agencies to have a good knowledge about the people and their main problems. Thus, a CBR programme should be seen as a slow and gradual process.

In addition, before any CBR activity starts, it is necessary to define the target area and to identify key persons and local institutions and organisations already present in the area. It is important to discuss and define the activities needed with community members and community leaders.

It may not be very easy to organise a meeting with community members, especially the family members of disabled persons and other vulnerable groups, to explain the ideas and to set in motion the first discussions, especially if the persons promoting the CBR programme are perceived as outsiders.

One possible initial step is to introduce a basic service, such as a nursery school or basic health care, or to strengthen an existing service, which would give the community a chance to interact with the initiating agency and to build familiarity and confidence. It would also allow the agency staff to learn about and discuss community needs, priorities and problems. Existing local initiatives started by concerned parents and groups can be very important and all those concerned can be involved in

discussions and planning from the outset. The identification and involvement of community leaders including influential persons, political and/or religious leaders become critical in this initial phase. For example, it is helpful to involve and inform local authorities such as civic authorities or police, etc. Both these activities may be difficult and require persistent and repeated efforts.

Identification and recruitment of key personnel belonging to the target communities and representing the religious or ethnic composition of the area are effective in building relationships of trust and confidence with the outside agency. More time and meetings may be needed to involve the communities in urban slum and poor areas as compared to communities in rural areas.

Understanding the needs

Carrying out a survey to identify disabled persons and other vulnerable population groups is helpful in defining the magnitude of the problems and for promoting discussions with local communities about priority activities and their implementation methodologies. However, such surveys may build up unrealistic expectations and lead to disillusionment even before the start of activities. Poor and slum communities may have past experience of surveys, making them suspicious and uncooperative.

Some project implementers prefer to proceed through gradual diligence and awareness building by promotion of dialogue and discussion with interested families and community members, rather than by promotion of any specific interventions. In this way, through a consultative process the communities themselves develop a plan of activities and the method of implementation. In such an approach, identifying the disabled persons and target groups in the community may be a slow and gradual process.

Other project implementers prefer to start with a gradual survey and, as the survey proceeds, promote certain activities, especially those that facilitate access to existing urban services such as hospitals, schools, vocational training, governmental assistance, etc. This may help in "spreading the word" among the target communities, thus improving collaboration for subsequent surveys.

The planning process should involve people in defining their needs and priorities, which may change with time. Thus, understanding the needs and planning of activities should be seen as an ongoing process.

Empowerment and community participation

Empowerment means that disabled persons and other target groups along with their family members and concerned persons in the community are aware of their rights and their collective strengths, have the necessary skills and resources to ensure access to existing services and facilities, and can take advocacy action to demand equal opportunities. Enabling empowerment is closely linked to community participation and ownership of the different aspects of the CBR programme. Promoting and/or strengthening DPOs and self-help groups (SHGs) is an important part of this process.

For example, countries have laws concerning access to transport and allowances for disabled persons about which persons living in urban low-income and slum areas may not be aware. A CBR programme in such a situation can provide information about these laws. Persons having this information may not know exactly how to benefit from

such laws and how to fill in the forms to obtain the required certificates, identity cards and other documents; CBR programmes can provide practical skills and help in this respect. Persons having both the information and the skills may still be unable to obtain the required documents because of a lack of fi-nancial resources necessary for the request, and the CBR programme can help by promoting savings and credit funds to provide loans in these si-tuations. Initially such information and skills may depend entirely on the staff of the initiating agencies, but persons from local communities can even-tually be trained to take on this role.

Promoting DPOs

CBR programmes can help in creating links between the communities and existing DPOs in the cities. They can also help in bringing together persons with disabilities, family members and other concerned persons in the formation of such local organisations. Through support for management and leadership training such organisations play a vital role in the CBR programme, for example, in awareness and information activities, as well as in running cooperatives and savings and credit funds.

CBR and community committees

Community committees may already exist in the urban low-income and slum areas, some of which may be involved with specific issues such as land rights and may not understand or regard disability as a priority issue. However, it is always important to try to inform and involve such committees in the CBR programme so that a CBR committee comprises disabled persons, their organisations, family members, concerned citizens, community leaders, etc. Persons representing specialised institutions that provide services to these areas may also be represented on such committees. To have a CBR committee that plays a role in management is the ideal goal for the CBR programme.

Role of public authorities

Persons living in the slums and the urban poor are citizens with rights equal to those of other citizens in the country. Involving local authorities to ensure public services and collaborating with existing governmental institutions are thus very important for CBR projects.

Role of CBR personnel

Initially the promotion of CBR activities in low-income and slum areas may require paid staff to work with the community. Such staff could ideally be from the target communities themselves; however, it may not be possible to find persons with the required training. The selection and training of paid staff to work in low-income and slum areas require special attention. The training must emphasise their role as facilitators and the overall goal of community take-over and ownership of the activities.

Role of community volunteers

Difficulties in finding community volunteers and their quick turnover are problems faced by CBR programmes and these difficulties may be accentuated in urban low-income and slum areas. However, there are examples of successful involvement of community volunteers in various projects, especially from among the disabled persons and their family members.

Activities

Health and rehabilitation

Disabilities are sometimes equated with

sickness, and persons with disabilities may be erroneously seen as sick persons. This may not be true for many persons with disabilities who are healthy. The CBR programme is able to play a key role in increasing the accessibility of existing institutional rehabilitation services in the cities for persons living in urban low-income and slum areas. The disabled persons or other target groups and family members can be accompanied to the rehabilitation services, and the bureaucratic formalities and procedures, etc., explained. Eventually, such roles can be taken over by local skilled persons in the communities.

However, such accessibility may be limited because of lack of time, and financial resources and community support may be required. Personnel, especially specialists from the existing institutional services, may be invited to visit the low-income and slum areas and become better acquainted with the needs and constraints of such communities.

The use of manuals such as the *WHO Manual on CBR* is important in providing knowledge about the causes and mechanisms of the various disabilities, as well as the range and limitations of rehabilitation activities offered to the disabled persons and their family members.

Education

CBR programmes can play a key role in creating awareness about the importance of education and in facilitating access to local schools. These programmes can also find solutions to obstacles such as the lack of a birth certificate.

CBR programmes can participate in creating awareness about the needs of disabled children among local schoolteachers and their training needs. It is important to promote the concepts of inclusive education.

In the community itself, the CBR programmes can help in promoting local nursery schools and ensuring that young children with impairments have access to these schools.

CBR programmes can also promote formal and informal education activities for adults at several levels.

Work and income generation

CBR programmes can play a key role in increasing accessibility of disabled persons and other target groups in existing services of vocational and skills training in the cities. This would provide a wider range of income generation activities.

CBR programmes can promote awareness about existing laws related to the employment of persons with disabilities. Those who are already employed may also appreciate support, and employers should also be made aware of disability issues.

CBR programmes can also promote training to create cooperatives and savings and credit funds. This would encourage self-employment. Information about obtaining loans, managing funds, bookkeeping, etc., could be included. Promoting self-employment is very important and persons arriving in the cities from rural areas may need support to integrate in the city and find their livelihood.

CBR resource centres

Lack of living space and overcrowding are key issues in urban low-income and slum areas. Identifying an actual phy-sical space where disabled persons, other target groups and family mem-bers can meet together and organise some of their activities is very useful

in such a situation. Suitable spaces in existing infrastructures are often identified by the communities them-selves - these spaces may be used only on specific occasions or during certain periods of the day or week for CBR-related activities. For example, in the slum CBR project in Mumbai (India) such activities take place in a building provided by different religious organisations; in the urban low-income area CBR project in Alexandria (Egypt) such activities take place in a school building; while in a slum CBR project in Korogocho (Nairobi, Kenya) a small hut was built specifically for this purpose. Such spaces are considered as "CBR resource centres".

Resource centres are also useful for organising technical support, training activities, etc., and they help community members to access learning resources such as books and toys. It is important to promote networking with other existing resource centres in the cities. A resource centre effectively provides an "address" for the community to receive communications and identity for the activities.

Creating links with other existing programmes

Several organisations and development programmes may be active in the same area, for example, organisations involved in vaccination programmes, women groups or education. Such organisations may be linked directly or indirectly to governments or they may be NGOs. The CBR programme should try to create links with these other programmes in order to promote an increased awareness about the situation and needs of disabled persons and other vulnerable target groups. In this way the other organisations can include them in their planned activities. Such links assist in organising joint activities to reinforce messages and skills, and to economise resources. Finally, such links may help to understand the community's involvement in different activities and to promote more realistic expectations from the CBR programmes.

The other organisations operating in these communities may be using charitable or intervention approaches, which make it very difficult for the CBR programme to promote community involvement and ownership. In such situations, it may be constructive to open a dialogue with the organisations to discuss the difficulties and strategies. CBR is a part of community development and it can act as a catalyst in bringing together community members and in engaging the more vulnerable among them in development activities.

Monitoring and evaluation

Apart from data on the number of disabled persons and other target groups benefiting from the different components of the CBR programme, key information about access to the existing city services and community participation and ownership needs to be identified and monitored. These aspects also need to be considered for evaluation and impact assessment, with a view to the sustainability of the CBR programme activities. Ideally, target groups and communities should be involved in the analysis and understanding of such monitoring and evaluation exercises, and their input used to plan new strategies and the future course of action. Information about the community and its needs is a resource for the community.

Conclusions

Promoting CBR activities to empower disabled persons and other target groups in urban low-income and slum areas, and

to increase their access to the available city services is a slow and gradual process. This process is based on recognition and reinforcement of existing resources in the communities and in the neighbouring cities, in collaboration with other organisations and programmes active in these areas. The projects that initiate such a process must be of a limited duration and with a gradual phasing out of the external agencies, so that the process may continue in the communities. Local institutions and grass-roots organisations are very important for the involvement of persons with disabilities and their families. ■

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Part III

POVERTY, HEALTH & DEVELOPMENT

OTHER ARTICLES

GLOBALISATION: A WAR AGAINST NATURE & PEOPLE OF THE SOUTH*

Vandana Shiva

Globalisation is often projected as a natural, inevitable, evolutionary process, which is bringing prosperity and growth, embracing us all and knitting us into a Global Village. Those who value equality and solidarity in the North support globalisation because it will allow the people of the South to join this Global Village. It is even assumed that only by participating in global markets do the Third World people get access to jobs and livelihoods.

However, globalisation does not create jobs, it destroys livelihoods and hijacks the resources of the poor. Globalisation is not a natural process of inclusion. It is a planned project of exclusion. It draws the resources and economies of the poor of the South into the global market place and global corporate ownership by displacing people from their life-support systems, livelihoods and lifestyles. It pulls resources and markets into the global economy while pushing the poor out of livelihoods both at the local and global level. The destruction of local economies and livelihoods is never counted. In fact the destruction of people's lives, livelihoods and cultures is defined as growth in the global economy. Growth through globa-lisation is based on the theft of people's resources, knowledge and economies. Global trade rules, as enshrined in the W.T.O. Agreement on Agriculture and in the Trade Related Intellectual Property Rights (TRIPs) Agreement are primarily rules of economic hijack, camouflaged by arithmetic and legalise. In this economic hijack, the corporations gain, and people and nature loose.

Rules of Market Competition: This war of corporations against people and nature is symbolised in the metaphors and logic of "market competition". The W.T.O. rules of market competition serve two functions. Firstly, they transform all aspects of life into markets. Culture, biodiversity, food, water, livelihoods needs, rights are all transformed and reduced to markets. Secondly, the destruction of the nature, culture livelihoods and ethics is then justified on the basis of the rules of competition. Violence and warfare is thus neutralised and rationalised.

All ethical and ecological rules, which sustain and maintain life are reduced to trade barriers. The obligation to protect the weak and vulnerable, the duty to give and share, the need to keep certain domains beyond commerce and commodification are all being dismantled as "protectionism". Co-operation and mutuality which is the very basis of ecological survival are rendered "illegal" by the W.T.O. rules of competition. Protection of people and nature is being replaced by corporate protectionism.

The global reach of corporations to take over the resources of the poor of the Third World is made possible not just by reduction and removal of tariffs. It is also made possible by removal of ethical and

* Excerpts from written speech sent for AIFO National Conference, November 1999

ecological limits on what can be owned as private property and what can be traded.

Globalisation is completing the **project of colonisation,** which led to the conquest and ownership of land and territory. Now biodiversity and water, the very basis of life's processes, which have so far been held in common by local communities for equal rights to biological sustenance and economic livelihoods are being colonised, privatised and commoditized.

Agriculture, which is still the primary livelihood for three quarters of humanity, and which is as much a cultural activity as an economic one, is also threatened through the "trade liberalisation" of agriculture, driven both by structural adjustment programmes of the World Bank and IMF, and the Agreement on Agriculture of the W.T.O. Globalisation of food and agriculture systems in effect means the corporate take over of the food chain, the erosion of food rights, the destruction of cultural diversity of food and the biological diversity of crops, and the displacement of millions from land based, rural livelihoods. The impact of a few years of globalisation illustrates the destruction in store for the planets and people if globalisation is not stopped and reversed.

Global free trade in food and agriculture is the biggest refugee creation programme of the world, which reduces Kosovo to insignificance. It is equivalent to ethnic cleansing of the poor, the peasantry and small farmers of the Third World.

I. Global Growth, Local Destruction.

(a) Seeds of Suicide

The epidemic of farmers' suicides in India is the most dramatic impact of trade liberalisation in agriculture. India is the home of cotton. The spinning wheel was transformed into the symbol of Indian's freedom from British colonialism by Gandhi. But under conditions of globalisation, cotton cultivation is pushing Indian farmers to suicide, and cotton has become a symbol of new slavery and new bondage. Globalisation led to increased exports. Increased cotton exports, led to increased cotton cultivation, including expansion into semi-arid areas such as Warangal in Andhra Pradesh where farmers earlier grew food crops for subsistence.

Warangal has not traditionally been an area for cotton cultivation. In this predominantly food crop area, cotton is a relatively new crop introduced under trade liberalisation. Under corporate push, farmers of Warangal switched over from their traditional paddy, pulses, millets, oilseeds and vegetable crops, which had sustained them to the sowing of cotton. Seed companies used video vans to show advertising films to sell hybrid cotton seed by promising that it would make them millionaires. Hybrid seed was sold as "White Gold". However, instead of becoming millionaires, the poor peasants were driven into a debt bondage from which they could be freed only though suicides.

Under the pressures of globalisation, not only did cultivation shift from food to export crops, and from mixed and diverse farming to monocultures, liberalisation had also led to a shift in seed supply from the farmers' seed and public sector seed to seed from private corporations. The new atmosphere of market liberalisation implied a withdrawal of regulatory systems in the seed sector. Companies could sell what they want and claim what they want without any system of social and public accountability. Untested and untried seeds were sold at high costs to gullible and innocent peasants who have no experience with dealing with

corporate vultures and whose local knowledge has been displaced by corporate advertising. Under corporate push unleashed by privatisation and globalisation, seeds also changed from open pollinated indigenous varieties which can be saved by farmers and are locally adapted to hybrids which need to be purchased every year at high cost and are ecologically vulnerable. Hybrids mean more profits for corporating, but higher costs for peasants and the environment.

Since monocultures and hybrids are very vulnerable to pest attacks, pesticide use also increased. Pesticide use in the district went up from $ 2.5 million in 1980s to $50m in 1997, a 2000% increase over a decade. Pesticides are war chemicals, which have unleashed a war against nature on our farms and fields. Beneficial species have been wiped out, increasing pest problems (2), since without predators, pests flourish. The more the pests increase through this war against nature, the more the peasants spray poisons. For poor peasants, this cost can only be borne through debts.

Since trade liberalisation has also led to budget cutbacks on extension services closing down of cooperatives and public sector banks, which provided rural credit at low interest, the peasants had to take high interest credit from the same companies which were selling hybrid seeds and pesticides. The corporations thus became money lenders, extension agents, seed suppliers and pesticide salesman rolled into one. The peasants were soon buried under the weight of unpayable debt. In 1998, more than 500 farmers committed suicides in Warangal district alone. The suicides have continued in 1999. Across India, more than 2000 peasants have committed suicides. Liberalisation of exports combined with liberalisation of the seed sector and liberalisation of credit has been responsible for the killing of peasants in India, the destruction of biodiversity and the poisoning of agro-ecosystems. Globalisation has removed all protection from farmers and nature. The epidemic of farmers' suicides in India is a symptom of the destruction inherent in globalising chemical and capital intensive corporate controlled agriculture.

In the regions where high costs of hybrid seeds and industrial agriculture introduced through globalisation are already pushing farmers to suicides, Monsanto has unleashed another war by introducing its genetically engineered cotton seeds. Most of the big Indian seed companies such as MAHYCO, Parry, Rallis have already been bought up by Monsanto.

While the argument used to promote genetically engineered crops in the Third World is that they will increase yields and decrease pesticides, the trials showed a decrease in yields and an increase in the use of pesticides.(3) If India had to adopt the Monsanto model, more farmers would be forced to commit suicides, more species would disappear, and more super pests would emerge. That is why on 9th Aug 1998, the day Gandhi told the British to "Quit India", we started the "Monsanto, Quit India" Movement. Farmers in Andhra Pradesh and Karnataka uprooted the genetically engineered cotton in protest, and we have filed a case in the Supreme Court to stop the introduction of genetically engineered crops in Indian Agriculture.(4)

The Third World does not need genetic engineering in agriculture. Genetic engineering introduces new ecological risks

and new economic costs which the Third World peasants cannot afford to take.5 Genetic engineering takes the war against nature and people to higher levels. While Monsanto was put out ads in Europe stating "more Biotechnology plants mean less industrial ones", it was building a new Round-up factory in India to sell its broad spectrum herbicide Round-up which in Monsanto's own words "kills everything green".

On the small farms of India where women use up to 150 - 200 species for food, fodder and medicine, the promotion of the use of Round-up is an ecocidal war against Biodiversity and a war against the biodiversity capital of the poor which is their only source of survival. In usual Monsanto speak, this threat to survival is sold as freedom and liberation. Monsanto's Round-up ads tell the rural women of India whose survival base is destroyed by Round-up, "Your hands are tied by weeds. Let Round-up set you free".

Chemical, pharmaceutical, biotechnology and seed companies have merged to create what are called "Life Sciences" corporations but are in reality "Death Sciences" Corporations. They are putting out seeds genetically engineered to be herbicide tolerant so that farmers are locked into dependence, biodiversity is destroyed, and agriculture is rendered more vulnerable. These corporations have also genetically engineered sterile seed, through what is called Terminator Technology so that farmers cannot save seed and are forced to buy seed every year.(6)

Monsanto controls large parts of the soybean and cotton seed supply through patents and through having acquired seed companies across the world, including Cargill, Dekalb, Agracetus, Asgrow, Calgene, Holden, Delta and Pine Land, MAHYCO, Rallis. The control over seed, the first link in the food chain is control over the food system. And it is control through the instruments of war that bring death and destruction to diverse species and poor people everywhere.

(b) From "Food First" to "Export First" Policies:

The Factor Ten Destruction: Trade liberalisation of agriculture implies the deregulation of trade in agricultural products. For the Third World this implies growing luxury crops for exports and importing food. Export oriented agriculture is creating an agricultural apartheid, with the Third World being asked to stop growing food and instead grow luxury products for the rich North. Production of food staples is concentrating in the U.S., and in hands of a few multinational seed companies and grain trading companies.

The shift from the "food first" to "export first" policy is justified on grounds of "competitiveness" and food security. Export earnings are supposed to pay for food imports. However, this never works. The displaced peasants cannot afford to buy imported food, and countries do not have adequate foreign exchange to import food. The hunger in Indonesia caused after the financial collapse is not linked to lack of food in Indonesia but lack of purchasing power of Indonesians. Since exporting luxury products to the west and importing staples destroys peasant livelihoods, the globalisation of agricultural trade creates massive food insecurity.(7)

Exports do not ensure food security because export oriented agriculture means changes in production systems from small scale sustainable production to large scale non-sustainable industrial production. It also implies changes in ownership over

natural resources and means of production, from small autonomous producer owners to large corporate and commercial interests. With export oriented agriculture peasants are displaced from farming and industrial and commercial interests take over land for production of export commodities such as shrimp, flowers, vegetables and meat. Displaced peasants are hungry people since they have lost their livelihoods and food entitlements.

Export oriented agriculture usually involves large scale industrial production. This has major environmental impacts, which leads to secondary displacement of small peasants. The luxury products being promoted for exports in all Third World countries are shrimps, meat and flowers. As a result, the rich get cheap shrimps and flowers and poor starve. While small scale, indigenous shrimp farming has been practised and has been sustainable over centuries, shrimp exports require the establishment of industrial, factory farms for shrimp production. Shrimp industry destroys coastal ecosystems and uproots coastal communities.

Each acre of a shrimp farm needs 200 shadow acres for absorbing the ecological costs of factory farming of shrimp. "Shadow acres" are the ecological unit which assesses how much area would be needed to supply resources and absorb the waste from a particular economic activity. Traditional fishing communities and coastal farming communities loose their resources and livelihoods to shrimp exports. Coastal fisheries are destroyed because mangroves are destroyed and pollution from shrimp factories is poured into the sea. Fifteen times more fish needs to be caught at sea and fed to shrimp than is produced in industrial aquaculture. Most of the feed is converted to waste and creates pollution. Coastal farming is destroyed because shrimp factories require the pumping of sea water into the large ponds for shrimp production. This causes salinization of ground water leading to a drinking water famine and destruction of trees and crops near shrimp factories. Women have to walk 10-20 kms in search of drinking water.
Shrimp exports are promoted as a major source of economic growth. However, for each dollar earned by corporations through exports of shrimp to consumers in U.S., Europe and Japan, $10 worth of livelihoods and natural resources are destroyed in the local economy. This includes the destruction of mangroves, water, agriculture and fisheries.8 Shrimp exports lead to a factor ten destruction for local ecosystems and local economies. Each time western consumers eat cheap shrimp, they are consuming the lives and resources of Third World coastal communities.

The inequalities aggravated or generated by export oriented agriculture also leads to violation of human rights and subversion of law and order. Trade can only be increased by taking resources away from people's subsistence and survival. When people fight to defend their human right to work and live, commercial interests who gain from exports mobilise private armies and the state apparatus to crush people's movements.

Exports of agricultural commodities are therefore often based on denying rural producers their right to life and livelihood. A few corporate and commercial interests, often linked to global corporate interests gain from exports. Most people loose what little they have. In most extreme cases they pay for exports in terms of their lives. The social and ecological costs of globalisation are borne by invisible people and are hence rendered invisible.

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Flowers, meat and vegetable exports, like shrimp exports, also do not allow countries to make up for food deficits through imports. As in the case of shrimp exports, meat exports have a shadow cost ten times more than export earnings in terms of the ecological functions livestock play in small scale agriculture. Meat exports are being promoted even in India, the land of the Sacred Cow. In fact, trade specialists have viewed the Sacred Cow as a "trade barrier". However, livestock are not just meat on legs. Livestock are the primary source of fertiliser in the form of organic manure and energy for farm operations, such as ploughing and agro-processing such as edible oil extraction from animal driven "ghanis". Livestock in India produce $17m worth of milk, $1.5b worth of food grain, $1 worth of organic manner and $17m worth of energy.10 Farm animals are the ecological alternative to fertiliser factories, tractors and large dams. Killing them for meat exports destroys more in the local economy than it creates in the global economy.

To export flowers, countries must import plant material, pesticides, Greenhouse equipment and pay for consultancy. India spent Rs. 13.7b in foreign exchange to import inputs for floriculture and earned only Rs. 0.3b from flower sales, thus having a net drain of Rs. 10b on scarce foreign change.12 Floriculture is based on intensive use of water and pesticides. If the resources used for floriculture had been given for food production, India would have produced four times more food than it could buy on global markets against flower sales. In terms of national food security, export oriented agriculture therefore destroys more than it creates.

Under the pressure of so called "liberalisation" policies, food prices have doubled and the poor have halved their consumption. Prices have increased because food has been exported, thus creating domestic scarcity. Land has been diverted from food crops to luxury crops for exports such as flowers and vegetable, and food subsidies, which used to keep food prices low have been withdrawn. As a housewife in Bombay stated "we are eating half of what we used to after food prices doubled in the last year. Even dal (pulses) is a luxury now. After milk prices increased, I stopped buying milk as well.(13)

As countries are forced to destroy their agricultural systems to grow and export commodities, both cultural diversity and biological diversity disappear. Diverse cereals, oilseeds, legumes are displaced by soybeans from the U.S. While exports destroy local food systems by diverting resources and changing ownership patterns, imports also destroy food systems by hijacking markets. In August 1999, after a very artificial case of mustard oil adulteration which was restricted to Delhi, but had affected all local brands of oil, mustard oil, the main cooking oil in North India was banned and all restrictions an edible oil imports were removed.(14) Soya bean and soya oil imports were liberalised or deregulated. Within one growing season millions of oilseed producing farmers growing mustard, ground nut, sesame, niger, had lost the market for their diverse oil seed crops. Liberalised imports of soybean have destroyed the entire edible oil production and processing in India. Millions of small mills have closed down. Prices of oilseeds have collapsed and farmers cannot even recover what they have spent on cultivation. Sesame, linseed, mustard have started to disappear from the fields as cheap, subsidised imports of soybean are dumped on the Indian market through "free-imports".

U.S. soybean is cheap, not because it is produced cheaply but because it is subsidised. The price of soybean is $155 a tonne, and this low price is possible because the U.S. government pays $193 a tonne to U.S. soya farmers, who would not be able to stay in production given the low commodity prices without government support. This government support is not really a farmer subsidy, it is an indirect corporate subsidy, since it subsidises corporate controlled agriculture. As the domestic market has flooded with soybean, which has been heavily subsidised with environmental and corporate subsidies, prices crashed to less than a third, local oil processing industry, from the small scale "ghanis" to larger mills started to close down. Farmers protesting against the collapse of their markets were shot at and killed. Due to trade liberalisation imports increased to 3 million tonnes in one year, a 60% rise compared to earlier years. Nearly $1 billion was spent on imports. Domestic oilseed production declined, and domestic edible oil prices crashed. Ground nut prices went down by 3% from Rs. 48 per kg. To Rs. 37 per kg. Liberalised imports of edible oil have meant the destruction of livelihoods of farmers, destruction of the local edible oil industry, destruction of biological diversity of crops and cultural diversity of food. It has also increased the foreign exchange expenditure, and worsened the balance of payments situation of the country.(15)

II. Hijack of Wheat - Both Bread and Freedom

Cargill is the largest of the giant grain trading corporations in the world. It is an international marketer, processor and distributor of agricultural, food, financial, and industrial products with approximately 80,600 employees in more than 1,000 locations in 65 countries and business activities in 130 more. Cargill controls over 70% of the world's trade in cereals. Together with other corporations, it controls 85% of the U.S. wheat exports and 95% of its corn, 90%of Canada's barley exports, l80% of Argentina's wheat exports and 90% of Australia's sorghum exports. Cargill is U.S.'s no.1 grain exporter, no.1 egg producer, no.1 soy bean crusher, no.1 oilseed processor, no.3 wheat packer, no. 3 corn miller and no.4 wheat miller.(16)

Cargill is the world's largest grain trader, which has bought up the second largest grain trading corporation, Continental Grain. Cargill seeds has in turn been bought up by Monsanto, which controls a major share of the seed market. Market openings through the Agreement on Agriculture are therefore market openings for the Cargills and Monsantos. In 1998, Cargill became the biggest exporter of protein meal from India - having exported 300,000 tonnes. It also exported 10,000 tonnes of non-basmati rice. During 1999, it has procured 10,000 tonnes of wheat. It has entered into an agreement with the Punjab Government to procure wheat and rice, develop grain handling and storage facilities, and enter into contract farming of wheat. It already has its own jetty in Jamnagar.

Corporations like Cargill can make billions through trade without contributing to production. For example, an editorial in a leading business daily in India had the title "Freeing wheat". Wheat does need to be freed from chemicals. However, it was neither wheat nor wheat farmers who were being freed from chemical addiction. The freedom being referred to was the freedom of Cargill to trade. In 1996, Cargill bought 2 million tonnes of wheat in India at $60 per tonne and sold it in international markets

at $240 per tonne , making a net profit of $360m.(17) A few months later, India had to import 2 million tonnes of wheat at international rates with scare foreign exchange due to domestic scarcity and rising food prices. India was poorer because it lost foreign exchange, for wheat it could have provided for itself, Indian farmers lost markets, and consumers had to pay more. Everyone lost, except Cargill. No extra wheat was produced but the export of 2m tonnes of wheat from India and the import of 2m tonnes of wheat to India appeared as 4m tonnes of extra wheat traded globally, which translated into more than $500m profits for Cargill.

Global agribusiness is now attempting to take over food processing by making fresh locally produced food appear backward, and stale food clothed in aluminium and plastic as "modern". Industrial processing and packaging was first applied to edible oils, destroying the livelihood of millions of oil mill operators and small farmers because of imported soybean. An attempt is now being made to take over the wheat economy. Wheat is called "Kanak" or gold in North India. The Indian wheat economy is based on decentralised small scale local production, processing and distribution systems. Wheat and flour (atta) provide livelihoods and nutrition to millions of farmers, traders (artis) and processors (Chakki Wallas - local flour mills).

In addition, flour is also produced by millions of women working at the household level. Women contribute significantly to the food economy through food processing. It is often said that only 2 per cent food is processed in India, because 98 per cent of the processing that women do at the household level is not counted because of the patriarchal bias in measuring economic value, economic growth and economic productivity. The rolling pin (belan) used for making "rotis" has always been a symbol of women's power.

The decentralised, small scale, household based economy of food production and processing is huge in aggregate. It generates millions of livelihoods while ensuring that fresh and wholesome food at accessible prices is available to people, and food production and processing has in negative environmental externality. Millions of Indian farmers grow 6050 million tons of wheat every year.(18) Most of this is bought as wheat by consumers from the local corner store (Kirana shop) and taken to the local "Chakki Walla". A chain of "artis" or traders bring the wheat from the farm to the local shops. It is estimated that more than 3.5 million family run Kirana shops supply wheat to Indian consumers. More than 2 million small neighbourhood mills produce fresh flour. While 40 million tonnes of wheat is traded, only 15 million tonnes is purchased directly as "atta" because Indians love freshness and quality in food. Less than 1 per cent of the consumed "atta" is branded because Indian consumers trust their own supervision of quality at the local chakki better than a brand name attached to stale, packaged flour.

This decentralised, small scale, economy based on millions of producers, processors and traders works with very little capital and very little infrastructure. People are the substitute for capital and infrastructure. Such a people centred economy is however a block to large scale profits for large scale agribusiness. They are therefore eyeing the Indian wheat economy to transform it into a source of profits. In an industry report entitled "FAIDA" (profit) the hijack of the wheat and atta supply by global agribusiness is described as the "wheat opportunity in India". The hijack plan is based on making

farmers directly dependent on agribusiness corporations for purchase of inputs such as seeds destroying local seed supply and displacing the local "artis" or traders and destroying the local "Chakki Walla's".

The destruction of the livelihoods of millions the destruction of the local decentralised economy based on small scale production, processing and distribution, the destruction of people's access to fresh and cheap "atta" is described as "modernisation of the food chain". Eating packaged food is described as the food culture of the rich. However, the rich eat fresh food in industrialised countries. It is the poor who are forced to eat heavily processed and packaged food. Packaging is not "modernisation", it is an obsolete concept that is merely an aspect of a non-sustainable economy that uses packaging and branding as a way to displace the more efficient and cheaper system through which people can get food processed locally in front of their eyes and hence ensure quality and freshness.

India's wheat and "*atta*" economy is complex and highly developed. Global agribusiness defines it as underdeveloped because the big players like Cargill and Archer Daniel Midlands (ADM) do not control it. As the FAIDA report states, "The Indian wheat sector is currently at a nascent stage of development". "Despite its importance, the industry is at a very early stage of improvement". The main criteria used to declare India's wheat economy underdeveloped is that the global corporations are missing from the scene. Underdevelopment is seen as absence of corporate control. "Development" is then defined as equivalent to corporate hijack of the economy. Decentralisation, local control, and small scale is defined as "nascent" and "underdeveloped", and monopolised food systems are defined as "developed". The hijack of the food system is thus made to appear as the "natural evolution" from small to big. Freshness and wholesomeness is defined as "low technology". Impure stale flour produced through "branding" is defined as "high quality". As the FAIDA report states, as a result of the inadequate technology used by the millers the shelf life of flour in India is typically 15 to 20 days. This is very short when compared to the six months to a year achieved in the U.S. Given the huge distances between the factory and the markets and the lengthy distribution system, the branded player has to ensure a much longer shelf life.

All positive aspects of food - freshness, local supply, low cost, low environmental impact, high nutrition are destroyed and substituted by negative characteristics - staleness, long distance supply, higher cost, high environmental impact due to long distance transport, packaging, and energy intensive milling, low nutrition due to over processing. The highest level of Orwellian doublespeak is being used to accomplish the hijack of wheat from Indian farmers and processors. Decentralisation is defined as "fragmentation" and centralisation is defined as integration, even though decentralised, locally controlled systems are highly integrated and centrally controlled systems are based on disintegration of ecosystems and local economic communities.

Agribusiness has already started to try and get Indian consumers to doubt their own quality control systems and trust the brand names. They see a corporate controlled market emerge which would generate RS. 3,000 crore or RS. 10 billion of profits through sale of packaged and branded at. But this profit will be based on the theft of livelihoods from millions of farmers, traders, and processors. According to the industry,

the "Chakki Walla" will be a thing of the past". But it will not be just be Chakki Walla's but also peasant farmers, local "artis", and local "Kirana" shop keepers.

The corporate agenda for India is to introduce U.S. style corporate monopolies in wheat such as those of Cargill and ADM and in seed such as those of Monsanto, Novartis, Dupont and Zeneca. These seed corporations demand monopolistic intellectual property rights to seed, forcing farmers to pay royalties for seed each while also controlling other inputs. This corporate dependence on seed and agrochemical inputs is already pushing thousands of farmers to suicide. The corporate control of agriculture is a 2 per cent model. It only allows 2 per cent people on land to be tractor drivers and pesticide sprayers. All other functions of farmers as maintainers of biodiversity, conservers of soil and water and seed breeders are destroyed.

Global corporations would like to see the decentralised small scale food systems of India replaced by large scale corporations like Cargill and ADM controlling the entire food chain from seed to procurement, processing and distributed. In the U.S., ADM works with "Growmark" - a cooperative of 175,000 farmers to provide credit, extension and markets. ADM owns 200 grain elevators, 1900 barges, 800 trucks, 130,000 railcars which move wheat around without any significant employment generation by using pneumatic blowers to load and unload grain. Investment in infrastructure is used to displace people, decentralised economic arrangements are replaced by centralised control over the food chain. The "FAIDA" report claims that 5 million jobs will be "created" by the take over of the food chain by MNCs. However, if one takes into account the 20-30 million farmers, 5 million Chakki Walla's, 5 million "artis", 3.5 million "Kirana" shops, and the households dependent on them, at least 100 million people's livelihoods and sustenance will be destroyed by the industrialisation of the wheat economy alone.

Globalisation of agriculture is in effect the coproratization of food systems. In the name of "free trade", both bread and freedom are being hijacked from the Third World by the Cargills and Monsantos. That is why during "Freedom Week", 1999, we protested at the Cargill Head Offices in India. While India was celebrating victory at Kargil, we talked of the hidden Cargill war - the war of global corporations against our culture, our health, and our livelihoods. An alliance of women's groups, environmental groups, farmers groups launched a movement for the protection of our bread and our freedom -"Hamari Roti, Hamari Azadi". Women made 'Rotis' at Cargills doorsteps, and with rolling pins as their symbol of food rights and food freedoms, they committed themselves to defending their diverse and decentralised food systems.

The food rights movement "Hamara Roti, Hamara Azadi" (Our Bread our Freedom) brings together environmental movements, women's movements, farmers' movements, workers movements, and student movements. The movement is mobilising awareness on corporations such as Monsanto and Cargill which are trying to control Indian agriculture and are destroying millions of livelihoods in food production and food processing, destroying the rich biological and cultural diversity of our agricultural and food systems, destroying the ecologically sustainable consumption patterns.

III. TRIPs and Biopiracy

One of the most perverse aspects of the W.T.O. is the Trade Related Intellectual

Property Rights (TRIPs) agreement which is forcing countries to reorganise their production and consumption patterns, to allow monopolies of a handful of so called "Life Sciences" corporations which are in reality peddlers of death. Genes, cells, seeds, plants and animals can now be patented and "owned" as intellectual property through the intellectual property rights agreement (TRIPs) of the World Trade Organisation (W.T.O)(23)

While the IPR systems are justified on grounds of creativity, the western Intellectual Property Rights or Patent Systems were not evolved as stimulants of creativity. They were instruments of conquests. Patents derives from "letters patent" - the open letters granted by European sovereigns to conquer foreign lands or to obtain import monopolies. Christopher Columbus derived his right to the conquest of the Americas through the letter patent granted to him by Queen Isabel and King Ferdinand.(24)

Patents were originally not granted for new inventions, but for bringing useful and known arts from other regions. Monopolies were granted for such technology transfer. The technologies did not have to be new for grant of patents. For example, monopolies were granted under Connecticut law for "bringing in the supply of goods from foreign parts that is not as yet of use among us". The non-recognition of prior art and prior use while granting patents has continued in the U.S. in spite of patents now being associated with novelty and creativity. The U.S. statute which was designed to make U.S. an independent industrial power was thus deliberately designed to deny prior art and hence treat ignorance of prior innovation as the ground of invention. Paradoxically, a legal system aimed at preventing "intellectual piracy" is itself based on legitimising piracy.

Originally, the U.S. laws were a patchwork of state laws, which did not offer protection for the patentee outside of the state in which it had been granted. The national statute was institutionalised in 1787 and became para 8, Section 8, Art. I of the Constitution of the U.S. The introduction of patents into the Constitution was triggered by steamboat monopolies, which had to be applied for in different states. On March 28, 1787, an entrepreneur was granted a patent in Pennsylvania which gave him the "sole and exclusive right and privilege of constructing, making, using, employing and navigating all and every species or kinds of boats or water craft which may be urged or impelled through the water by the force of fire or steam, in all creeks, rivers, bays and waters whatsoever, within the territory and jurisdiction of this state, for and during the full end and term of fourteen years". Members of the constitutional convention, which was sitting in Philadelphia, were taken on board a steamboat during their deliberations. The politicians were convinced that a "single federal patent law would serve the fledgling nation and its inventors for more effectively than the existing patchwork of state patents.

The broad steam-boat patents to make, use, navigate "all and every species" of steamboats were granted in the U.S. in spite of the steam engine having been invented and patented by James Watt in Scotland 15 years before. Prior art and prior use in other countries was therefore systematically ignored in U.S. Patent Laws. The same assumption of ignorance as invention is enshrined in the U.S. Patent Act of 1952. Section 102 of the Act treats as a prior art use in the U.S. and publications in foreign countries. Use in foreign countries is not recognised as prior art. Section 102 of the U.S. law, which defines prior art reads as follows:

35 USC 102: Conditions of patentability: Novelty and loss of right to patent. A person shall be entitled to a patent unless: A. The invention was known or used by others in this country or patented or described in a publication in this or a foreign country before the invention thereof by the applicant for patent. Or B. The invention was patented or described in a trade publication in this or a foreign country or in public use or on sale in this country more than one year prior to the date of the application for patent in the United States.

Use in a foreign country therefore does not constitute prior art in U.S. patent law. Since patents are granted for new inventions, denial or non-recognition of prior art elsewhere allows patents to be granted for existing knowledge and use in other countries. This is the basis of Biopiracy or knowledge of Indian knowledge systems, and indigenous uses of biological resources being patented. As Peter J. Thana has stated, the statute talks about things that are publicly known and publicly used in this country before the date of invention. You should not be able to claim as your invention, something that was on the shelf, out there, before you invented it.

Prior art excludes devises in use elsewhere in the world. If, for example, somebody in Europe were operating a machine and you independently and without knowledge of the existence in good faith developed your own invention that was essentially the same machine, that fact would not prevent you from obtaining a patent in the U.S.
The European invention would not be considered prior art in the statute.(25)

The U.S., therefore, depended on borrowed knowledge for its own development on industrial power. However, a century later, the U.S. wanted such transfer of knowledge and technology to be blocked. Instead of changing its laws to reflect the prior innovation and indigenous knowledge of other countries and cultures, the U.S. created unilateral instruments such as clause Special 301 in its Trade Act to force other countries to follow its Patent laws. In addition, the U.S. globalised its flawed Patent laws by bringing intellectual property rights into trade laws in GATT.

Intellectual property rights, or rights to "products of the mind" were introduced into the trade regime during the Uruguay Round of GATT. Not only were IPR laws made global geographically, in the sense that all countries were brought under TRIPs laws, TRIPs also removed ethical boundaries by including life forms and biodiversity into patentable subject matter. Living organisms and life forms, which are not inventions but make themselves were thus redefined as machines and artefacts, made and invented by the patentee. Intellectual Property Rights and patents then give the patent holder a monopolistic right to prevent others from making, using, and selling seeds. Seed saving by farmers has now been redefined from a sacred duty to a criminal offence of stealing "property" from corporations. Article 27.3 (b) of the TRIPs agreement, which relates to patents on living resources was basically pushed by the Life Sciences Companies to establish themselves as Lords of Life.

The U.S. Corporations like Monsanto have admitted that they drafted TRIPs and pushed it into international law. As a Monsanto spokesman said, The industries and traders of world commerce have played simultaneously the role of patients, the diagnosticians and prescribing physicians.

There are three perversions inherent in patents on living material. The first is the ethical perversion, intrinsic to the claim that seeds, plants, sheep, cows, human cell lines are nothing but "products of the mind" "created" by Monsanto, Novartis, Ian Wilmut or PPL. Living organisms have their intrinsic self - organisation, they make themselves, and hence cannot be reduced to the status of "inventions" and "creations" of patent holders. They cannot be "owned" as private property because they are our ecological kin, not just "genetic mines".

The second perversion intrinsic to patents on life is that it converts the most important duty in agriculture - to save seed and share seed - into a crime. The recognition of corporations as "owners" of seed through intellectual property rights converts farmers into "thieves" when they save seed or share it with neighbours. Monsanto hires detectives to chase farmers who might be engaging in such "theft".

The third perversion in the global IPR system is that while it is supposed to prevent "piracy", it actually encourages it in the form of "Biopiracy", the theft of biodiversity and indigenous knowledge through patents.

Biopiracy deprives the South in three ways:

1. It creates a false claim to novelty and invention, even though the knowledge has evolved since ancient times. Thus, biopiracy is intellectual theft, which robs Third World people of their creativity and their intellectual theft.
2. It diverts scarce biological resources to monopoly control of corporations thus depriving local communities and indigenous practitioners. Thus, biopiracy is resource theft from the poorest two third of humanity who depend on biodiversity for their livelihoods and basic needs.
3. It creates market monopolies and excludes the original innovators from their rightful share to local, national and international markets. Thus, biopiracy is economic theft.

Instead of preventing this organised theft of the resources and knowledge of the poor by powerful corporations, W.T.O. rules protect the powerful and punish the victims. In a dispute initiated by the U.S. against India, W.T.O. forced India to change its patent laws and grant exclusive marketing rights to foreign corporations on the basis of foreign patents. Since many of these patents are based on Biopiracy, W.T.O. is in fact promoting piracy through patents. Overtime, the consequences of TRIPs for the South's biodiversity and southern people's rights to their diversity will be severe.

These consequences include:

a. No one will be able to produce/reproduce patented agriculture/medicinal/animal products freely, thus eroding livelihoods of small producers and preventing the poor from using their own resources and knowledge to meet their basic needs of health and nutrition.
b. Royalties for their use will have to be paid to the patentees and unauthorised production will be penalised, thus increasing the debt burden, which is already crushing the Third World.
c. Indian farmers, traditional practitioners and traders will lose their market share in local, national and global markets.

The patents on the anti-diabetic properties of *karela, jamun, brinjal* once again highlight the problem of Biopiracy - the patenting of indigenous biodiversity related knowledge. U.S. Patent No. 5,900,240 was granted recently to Cromak Research Inc. based in

New Jersey. The use of karela, jamun and brinjal for control of diabetes is everyday knowledge and practise in India. Their use in the treatment of diabetes is documented in authoritative treatises like the "Wealth of India", the "Compendium of Indian Medicinal Plants" and the "Treatise on Indian Medicinal Plants".

This indigenous knowledge and use consists of "prior art". No patent should be given where prior art exists since patents are supposed to be granted only for new inventions on the basis of novelty and non-obviousness. These criteria establish inventiveness, and patents are exclusive rights granted for inventions. The claim to the use of karela or jamun for anti-diabetic treatment as an invention is false since such use has been known and documented widely in India.

Biopiracy and patenting of indigenous knowledge is a double theft because first it allows theft of creativity and innovation, and secondly, the exclusive rights established by patents on stolen knowledge steal economic options of everyday survival on the basis of our indigenous biodiversity and indigenous knowledge. Overtime, the patents can be used to create monopolies and make everyday products highly priced.

If there were only one or two cases of such false claims to invention on the basis of Biopiracy, they could be called an error. However, Biopiracy is an epidemic. Neem, haldi, pepper, harar, bahera, amla, mustard, basmati, ginger, castor, jaramla, amaltas and new karela and jamun..... Ricetec, a U.S. corporation has a patent on India's famous basmati rice. W.R. Grace, a chemical company that killed children in Massachusetts by toxic pollution, has many patents on products derived from the Indian Neem tree, Azadirichta Indica.

The problem is not, as was made out to be in the case of turmeric, an error made by a patent clerk. The problem is deep and systemic. And it calls for a systemic change, not a case by case challenge. If a patent system which is supposed to reward inventiveness and creativity systematically rewards piracy, if a patent system fails to honestly apply criteria of novelty and non-obviousness in the granting of patents related to indigenous knowledge then the system is flawed, and it needs to change. It cannot be the basis of granting patents or establishing exclusive marketing rights.

The problem of Biopiracy is a result of western style IPR systems, not the absence of such IPR systems in India. Therefore, the implementation of TRIPs, which is based on the U.S. style patent regimes, should be immediately stopped and its review started. Since patents are granted for new inventions, denial or non-recognition of prior art elsewhere allows patents to be granted for existing knowledge and use in other countries. This is the basis of Biopiracy or knowledge of Indian knowledge systems, and indigenous uses of biological resources being patented.

U.S. style patent laws can only pirate indigenous knowledge. They cannot recognise or protect it. The survival of an anachronistic Art. 102 thus enables the U.S. to pirate knowledge freely from other countries, patent it, and then fiercely protect this stolen knowledge as "intellectual property". Knowledge flows freely into the U.S. but is prevented from flowing freely out of the U.S. If Biopiracy has to stop, then the U.S. Patent laws must change, and Article 102 must be redrafted to recognise prior art of other countries. This is especially important given that U.S. patent laws have been globalised through the TRIPs agreement of the W.T.O. In 1999, article 27.3 (b)

of the TRIPs agreement is supposed to come up for review. This is the article that most directly impacts indigenous knowledge since it relates to living resources and biodiversity. In 2000 A.D. countries can also call for an amendment of TRIPs as a whole.

Since TRIPs is based on the assumption that U.S. style IPR systems are "strong" and should be implemented world-wide, and since in reality the U.S. system is inherently flawed in dealing with indigenous knowledge and is "weak" in the context of Biopiracy, the review and amendment of TRIPs should begin with an examination of the deficiencies and weakness of western style intellectual property rights systems. A globalised IPR regime which denies the knowledge and innovations of the Third World, which allows such innovations to be treated as inventions in the U.S., which legalises monopolistic exclusive rights by granting of patents based on everyday, common place indigenous knowledge is a regime which needs overhaul and amendment.

Instead of being pressurised, as India has been, to implement a perverse IPR system, through TRIPs, India should lead a campaign in W.T.O. for review and amendment of the system. Meantime, India and other Third World countries should freeze the implementation of TRIPs. While TRIPs implementation is frozen for starting a process of review, we should make domestic laws, which protect our indigenous knowledge as the common property of the people of India, and as a national heritage. The implementation of the Convention on Biological Diversity enables us to do this. Since CBD is also an international treaty, protecting indigenous knowledge via a Biodiversity Act does not violate our international obligations. In fact removing the inconsistencies between TRIPs and CBD should be an important part of the international campaign for the review and amendment of TRIPs.

Amending TRIPs and U.S. Patent laws is the challenge we must take up. The problem is not our IPR systems but the western style IPR regimes, which systematically enable piracy of indigenous knowledge and practices through patents. The review of TRIPs should be used to start amending these deficient systems. Some commentators have suggested that Biopiracy happens because our knowledge is not documented. That is far from true. Indigenous knowledge in India has been systematically documented, and this in fact has made piracy easier. And even the folk knowledge orally held by local communities deserves to be recognised as collective, cumulative innovation. The ignorance of such knowledge in the U.S. should not be allowed to treat piracy as invention.

Piracy of indigenous knowledge will continue till patent laws directly address this issue, exclude, patents on indigenous knowledge and trivial modifications of it, and create sui generis systems for the protection of collective, cumulative innovation embodied in indigenous knowledge. The protection of diverse knowledge systems requires a diversity of IPR systems, including systems, which do not reduce knowledge and innovation to private property for monopolistic profits. Systems of common property in knowledge need to be evolved for preserving the integrity of indigenous knowledge systems on the basis of which our every day survival is based and through which the biodiversity of the world has been protected and conserved.

Since neither TRIPs, nor the U.S. Patent law have scope for recognising knowledge as a "commons", or recognising the collective, cumulative innovation embodied in indigenous knowledge systems, if indigenous knowledge has to be protected, then TRIPs and U.S. Patent laws must change. Nothing less than an overhaul of western style IPR systems with their intrinsic weaknesses will stop the epidemic of Biopiracy. And if Biopiracy is not stopped, the every day survival of ordinary Indians will be threatened, as overtime our indigenous knowledge and resources will be used to make patented commodities for global trade. Global corporate profits will grow at the cost of the food rights, health rights and knowledge rights of one billion Indians, two thirds of whom are too poor to meet their needs through the global market place. India should loose no time in starting the movement for amendment of TRIPs and U.S. Patent laws. Our survival itself is at stake.

Instead of removing perversions of U.S. patent law that allows existing knowledge to be treated as 'novel' and patented, the Trade Related Intellectual Property Rights (TRIPs) Agreement of GATT/W.T.O. has univer-salised the U.S. patent perversions of patenting life and protecting biopiracy. The potential costs of Biopiracy to the Third World poor are very high since two thirds of the people in the South depend on free access to biodiversity for their livelihoods and needs. 70 per cent seed in India is farmers' seed. 70 per cent healing in India is based on indigenous medicine using local plants.

Patents on indigenous knowledge and uses of plants is an "enclosure" of the intellectual and biological commons on which the poor depend. Robbed of their rights and entitlements to freely use nature's capital because that is the only capital they have access to, the poor in the Third World will be pushed to extinction. Like the diverse species on which they depend, they too are threatened species. Integrity and intrinsic worth of all species, and the right to life of all, rich and poor alike, calls for an exclusion of life forms from TRIPs. The review of Art. 27.3 (b) in 1999 and the review of the entire TRIPs agreement beginning in 2000, should be used to initiate the exclusion of life forms from patentability so that we can begin the ecological and ethical rehabilitation of including humans in the democracy of life with the limits and obligations that being a member of the earth-family entails.

"No patents on life" Movements and Movements against Biopiracy are already strong in the North and South. These citizens' initiatives need to be the basis of the TRIPs to exclude life from patents and IPR monopolies. In India, Navdanya (the movement for conservation of native seeds) has catalysed broad based alliances for food freedom and seed freedom with farmers' groups, women's groups, environmental groups. The Bija Satyagraha or Seed Satyagraha is the non-cooperation movement against patents on life, genetic engineering of crops and corporate monopolies in agriculture.

The "Jaiv Panchayat" Movement or the Living Democracy Movement is the movement for the protection of all species and for local democratic control on biodiversity and indigenous knowledge. During Freedom Week, 9th-15th August 1999, through the Living Democracy Movement, more than 500 village communities sent notices to Biopirates such as W.R. Grace for its biopiracy of Neem as pesticide, Monsanto, whose subsidiary Calgene, has patents on Mustard and Castor, and RiceTec which has a patent on

Basmati. Notices have also been sent to W.T.O. for overstepping its jurisdiction since under traditional legal systems and under the Indian Constitution, the local community (Gram Sabha) is the highest competent authority on matters related to biodiversity.

The rules of W.T.O. reduce life's diversity to a commodity, and force all cultures to be ruled by giant corporations. The living democracy movement celebrates the diversity and intrinsic worth of all life forms, and strengthens decentralised democratic structures for the defence of life and livelihoods. W.T.O. has forced India to change its patent laws, hand over our seeds to Monsanto and bread to Cargill, remove Quantitative Restrictions on agricultural imports and allow MNCs to take over our food production and food processing from our small farmers and small-scale processing at the level of households and cottage industries. We are calling on W.T.O. to quit India's food and biodiversity.

We want W.T.O. to Quit India so that our farmers, our biodiversity and our people can live. We want agriculture to be out of the W.T.O. on grounds of our food security. This will be the basis of our campaign for the review of Agreement on Agriculture in the W.T.O. Food production should stay in the hands of the small farmers and food security should stay in the hands of the women.

The TRIPs agreement of W.T.O has an impact on biodiversity and thus subverts our democratic rights to our biodiversity and indigenous knowledge. Biodiversity should stay in the hands of the local communities. This is a right recognised in our traditions and enshrined in our Constitution. W.T.O. is destroying our democratic decision-making structures by forcing the government to implement TRIPs and undo the rights of the people to govern themselves through decentralised democratic structures guaranteed under the Panchayati Raj System.

The Gram Sabha or local community as the competent authority for the defence of biodiversity and the protection of indigenous knowledge as collective and cumulative innovation will be the basis of our campaign for the review of the TRIPs agreement. The real millennium round for the W.T.O. is the beginning of a new democratic debate about the future of the earth and the future of people. The centralised, undemocratic rules and structures of the W.T.O. which are establishing global corporate rule based on monopolies and monocultures need to give way to an earth democracy supported by decentralisation and diversity - in which the rights of all species and the rights of all peoples come before rights of corporations to make limitless profits through limitless destruction.

Free trade is not leading to freedom. It is leading to slavery. Diverse life forms are being enslaved through patents on life, farmers are being enslaved into high-tech slavery, countries are being enslaved into debt and dependence and destruction of their domestic economies. We want a new millennium based on economic democracy, not economic totalitarianism. The future is possible for humans and other species only if the principles of competition, organised greed, commodification of all life, monocultures and monopolies and centralised global corporate control of our daily lives enshrined in the W.T.O. are replaced by principles of protection of people and nature, the obligation of giving and sharing diversity, decentralisation and self-organisation enshrined in our diverse cultures and national Constitutions.

The W.T.O. rules are violative of principles

of human rights and ecological survival. They are violative of rules of justice and sustainability. They are rules of warfare against people and planet. Changing these rules is the most important democratic and human rights struggle of our times. It is a matter of survival. ■

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Follereau Would Say Today*

Alex Zanotelli

So many realities have always bound me to AIFO and I feel like expressing my voice and my thoughts through the medium of this video-cassette – a video, which can bring to you the issues of the poor. Thanks for giving me this possibility for being with you and speaking to you this way. Thanks above all for the long years for which, we have walked together, we were faces for each other, and we encouraged each other. Some times, we criticised each other, but we need to do that so that cry of the poor can be heard.

Significance of 11th September 2001: We are passing through a particularly difficult moment, a very delicate moment. While you all sit through the conference, so many of us have agitation in our heart. Since the attack on twin towers and Pentagon on the last 11th September, it seems as if something new has happened. These are part of those epoch-making events, which form part of human history. What had seemed impossible before, now we see that it is already here. It is a dramatic moment, most of all for the heart of the empire. It had never felt so touched, it had never felt the human suffering from so close. Earlier, the suffering was always at the peripheries of the empire, today the heart of the empire is bleeding and this has resulted in some incredible mechanisms. What ever has happened in New York and Washington is painful to all of us, it makes the whole world feel sad, but I can't accept that there be "deaths of the first class" and "deaths of the second class", that there be persons for whom we cry and raise our flags, and so many other persons at whose death, no one cries. I can't accept that there be deaths of A-class and deaths of B-class. Human being is unique, an indivisible reality, every person has a face, every person reflects that divine mystery, all persons have their dignity, all persons are an end in themselves. If I have to cry for five thousand persons killed in New York and Washington, I must also cry for those 30-40 million persons who are burnt in front of the money-god every year, those who die hungry and no one cries for them. I have to cry for all the persons, the boys and the girls of Korogocho, who die like flies from AIDS, and no one cries for them. This is not just. If we are going to cry for the dead of A-class, we have to cry for all of them, for those two and half million killed in that absurd war in Congo, made for getting the riches. This is what that the empire and its heart must understand, Europe and America must understand – if persons are dying today, it is not just for international terrorism – I agree that it must be fought – but there are so many more persons who are killed because of our economic and military terrorism. Killing persons through hunger is terrorism, killing persons for the absurd wars as the wars in Congo and Sierra Leone, is also terrorism. All these deaths are result of terrorism.

Need to Change the System: What I ask is that let's discuss again this whole system, which does nothing except to create death

* Excerpts from video-speech at AIFO National Conference, October 2001

every where and we rich think that we are going to save ourselves through an impenetrable security, we only illude ourselves. It is only a fantasy, as America has now shown. There is no security any where except in justice that can bring fruits of peace. What I ask is that we discuss this system of economic apartheid that allows 20% of the world to live like kings, consuming 80% of the world resources, leaving 80% of the world to live at the threshold of poverty and for one and half billion persons to live in absolute misery. This is terrorism like the one, which attacked New York and Washington.

Follereau expressed this in one world, Leprosy. It is not just leprosy patients. The whole world has leprosy, a world submerged in different leprosies. I would like to come back to Raoul Follereau, a man who fascinated me since I was a boy, one of those who inspired me. I have read many of his books and I am grateful to AIFO and the EMI editors for translating all those books, which touched me so deeply. I think that Follereau was a genius, he understood the issues, starting from a very simple concept – the leprosy. Starting from leprosy, he was able to read all the reality of leprosies and to commit himself, not just for fighting leprosy but for fighting all the leprosies, because our whole tissue is sick. This is the relevance of Follereau today, to look at all the leprosies. If there is this system of economic apartheid, which is producing the biggest disaster today, it is because we are living in that situation of leprosy called "the market economy", the liberalism, where everyone can do what they wish. The "law of the market" is the new god. This is indeed one of those big leprosies, which makes so many persons to be sacrificed to the god of profit.

There is a political leadership, but it does not make politics, it is subservient to economy. Our is a leprosy-politics, which prostitutes itself, which sells itself to profit, like the king of earth selling himself to the beast. There is a military-leprosy which is awesome, it manages to consume 900 billion dollars each year, when according to the World Bank 13 billion dollars per year would be sufficient to fight hunger and some big diseases in the world. Ours is pure craziness. This system of economic apartheid can continue to be, on the strength of arms and armies. The rich continue to spend and waste in armaments. United States is renewing its nuclear armaments for a cost of 60 billion dollars, Bush wants a space shield. This is the real reason for our disaster and our terrorism. This incredible military-leprosy is linked to the spineless politics, which has passed over the power to free-market, to the multinationals, and above all to finances, because the heart of the economy today is finances.

Relevance of Raoul Follereau Today: This is what I call leprosy and Raoul Follereau would have called leprosy. This is the relevance of Follereau today. He was a good lay person, he was not some missionary or what ever, he was married and had a big lay spirituality, and he founded his commitment on those values, which we call lay values. This is what we need today – authentic values. It is time that we Christians, and I say this with utmost seriousness, can get out of the trap of considering ourselves the "good ones". There are so many authentic values outside the church as well, in other religions. The spirituality of Follereau is in affirming those lay spiritual values, which must emerge and the church should have the courage to say that "this is the true message of Gospels". The values are not just inside the church, they are all those persons, like Raoul Follereau, who come as a ray of light.

Like when he had the courage to write to Kennedy and Khruschev: "Give me the value of one bomber plane and I shall fight leprosy with that". He was completely unheard. The military of the two super-powers didn't give him any bomber plane. Now you read what Gorbachov has written after the attack in USA - "we surrendered to the military apparatus and gave in to their imperatives". This was the logic and greatness of Follereau. "It is by loving", he used to say, "that we can save the world". We need a civilisation of love. Follereau had also thought of how to link all these issues facing humanity, so now stop believing that I love, so I am ok and the world is safe. You won't save any thing. Love must be our fundament, our basis, but I must be aware that the world is profoundly egoist, based on deep injustice, and if I don't change this economic, political and military world, all my love doesn't serve any thing. We need to be capable of passing from personal to structural, from personal to cultural. This was also the grand vision of Follereau: it can't be conceived to weaken leprosy by just fighting against the disease, we must fight against all leprosies.

If we can spend that money, which is being used for bombing Afghanistan now, for fighting diseases, perhaps we can have our paradise on earth, instead of this hell that we have now. I say this now from Korogocho, which is the emblem of the absurd, a miniature copy of the larger world. Nairobi has 4 million persons, more than 2 million of them are forced to live in less than 1.5% of the land of Nairobi. Even this tiny piece of land does not belong to the poor, it belongs to the Government, who can throw us out, if and when they wish. Even worse, that 80% of these slum dwellers are on land, which is not their but they pay the rent for it, they don't even own the hut where they live. This is the situation of the world in miniature. I am speaking of this suffering of Korogocho from the economic apartheid of Nairobi, because that is what it is. For the pleasure of the innocent eyes of the white tourist, the wild animals are treated much better than the human beings of Korogocho, who live in 100,000 in a area of 1.5 km by 1 km. This is profoundly unjust, this is a sin.

Health Apartheid and Economic Apartheid: Even you, by your fight against the health-apartheid are fighting against the economic apartheid. The fact that number of leprosy cases are increasing rather than decreasing proves this. There are not enough funds to conduct research against leprosy because it does not interest big pharmaceutical companies, it does not interest the rich. I was recently reading and I was quite shocked by it that more than 90% of funds for research are used for those 10% problems affecting rich countries while 90% diseases like pneumonia, diarrhoea, tuberculosis, etc. affecting the poor countries, get less than 10% of the research funds. Some times the drugs for these diseases go out of production and no one invests money to find new drugs useful for fighting these diseases. While the big pharmaceuticals are busy researching drugs for conditions related to life-styles like obesity, infertility, impotence, etc., persons in poor communities continue to die from banal and easily curable diseases. We must remember that even in this case, Africa represents one of the worst expressions of this health-apartheid. Of the 34 million of AIDS patients, Africa has 24 million and their destiny is to die soon. AIDS and hunger are like a bush-fire, spreading and killing. This is why I smile at the courage of G8, it is a big courage that they have, they have promised to give 1.3 billion dollars for the fight against AIDS. Is this a real joke? Divided for 34 million, it becomes less than 30 cents per person affected with AIDS. What is the use of such

donations? It was enough that G8 could tell the big pharmaceuticals that they have made enough profits and they must sell the anti-AIDS drugs to poor countries at an accessible price. That would resolved some of this problem of health-apartheid. It would have been sufficient to partially solve one of the biggest problems of humanity today.

The politics must assume its sovereign role, it must come back to guide the poles and the world. We can't leave the world in the hands of military apparatus. We must have an effective return to legality, to political decisions on problems of the whole human family. This is the importance of this moment that we are living. Follereau had understood this by starting from leprosy. We live in a world in which, a part of humanity, 80% of humanity is looking at the beautiful aquarium in which the golden fish are swimming. This is the heart of our problem. I liked very much this book and the introduction made by Bishop Dom Moacyr Grecchi, cited by Jean Guitton, a great Christian our times, "The first world is like a golden island, against which crash the waves of unhappiness of others. How can you stop that the ocean of unhappiness, which is rising up in a storm, does not flood and swallow in its fury these golden islands?". He also cites Proust, "It is a big social question to know if the glass wall will eternally protect the banquet of marvellous animals and if the dark men, who look in from the darkness of the night, will not come in their aquarium to eat them up". Terrible words, these words of Bishop Grechi, which echo in our ears like a terrible prophecy.

What has happened in New York and Washington is the needle has touched the heart of the empire. What the future is going to bring, is going to be fearsome, if we shall not decide to bring a change. This is the relevance of the message of Follereau today, to come back to your words and to those of your teacher, whom I consider as one of the great men of our time like Mahatma Gandhi, Martin Luther King. He had said, "You have to a movement. The battle of leprosy, is just one chapter of that fight in which, we all must engage, against the different leprosies, much more contagious than leprosy because they are hunger, misery, egoism, fanaticism and indifference. From our fight against leprosy disease, we have to learn how to fight against these other leprosies." Here in Korogocho, I live with a small community of leprosy-affected persons, who go out to beg every day. It is one of the most beautiful Christian communities that we have here. This morning I was with them and it was beautiful when we read that part from the Gospel where Jesus cured 10 leprosy affected persons. One of them said, "Thanks for accepting us. Thanks because here we feel like brothers and sisters. This is a great gift."

This is my appeal to you, dear "Amici di Follereau", do not become a small corporation, do not become an agency, a non-governmental organisation, be faithful to the prophetic voice of the one who inspired you, be just a movement and unite with other movements. We need to break the walls. Not through violence. We have radically refused any kind of violence. We must unite through Lilliput like links, to build another world, a world different from the one we find ourselves in. This was the great intuition of Raoul Follereau, on which we are moving. Do not lose heart: to feel impotent of producing any change is a big sin. Each of you is a positive atomic energy bomb, use it positively for common good and you will see the birth of a new world. Thank you. ■

Marginalization: Cause and Effect of Poverty

EXAMPLE FROM PAKISTAN

Farhat Rehman

One fifth of the world population lives below the poverty line today. In Pakistan, poverty is deeply rooted in its colonial history. Pakistan is an Islamic country with its own history and cultural heritage.

General Information about Pakistan: To the west is Peshawar, the capital of North West Frontier Province and gateway to Khyber Pass, the western approach to the subcontinent. In the South is Hyderabad and metropolis of Karachi. In the North are places like Swat Valley, Chitarl Valley, Gilgit, Hunza and Baltiatan, the most beautiful and unspoilt regions in the world.

Islamabad is the national capital, 20 Kms from Rawalpindi, which is situated on the Grand Trunk Road, between Lahore and Peshawar. Rawalpindi, having a population of about 5 million, is one of the oldest settlements along the Khyber-Peshawar-Lahore route. Pakistan stretches from the Arabian Sea in the South to the Tibetan Plateau in North, over a total area of 796,000 sq. kms. It consists of four provinces: Sind, Punjab, Baluchistan and North West Frontier Province; plus the northern territory of Gilgit-Hunza, Baltistan and liberated part of Kashmir.

The country is divided into six geographical regions, where the Indus river forms the backbone of the whole country. From Tibet it crosses Ladakh close to Chinese border and transverse the Karakorams into the plains. The plains end with the Salt Range of the Potwar Plateau, and from here it finally meet the Hindukush, the Karakorams and the Himalayas. Except for the Indus plains, the whole country is hilly deserts, plateaux and great mountains.

The population is now reaching 140 million, about 70% of them living in rural areas. Karachi is the biggest city, with 11 million populations, a metropolitan city. Lahore, the magnificent city is a Mughal masterpiece. Lahore is the second biggest city of Pakistan with population of about 9 million.

Economic Development of Pakistan: After partition from India in 1947, from 1950's onwards, by the end of decade of development, the national wealth had become concentrated in just 22 families of the country. The wide income gap between the population divided Pakistan from Bangladesh in 1971. After that, the capitalistic economic policies were reversed, and there was massive nationalisation of industries, banking and financial sectors, trading, education and health services.

But still economic growth of Pakistan continued to decline and kept fluctuating. Post 1988 economic scenario, was affected mainly by poor planning in 70s and 80s, which caught up with the national economy in 90s, which has witnessed the worst economic situation of our country, especially during post nuclear explosion period.

During 1990s our economy became increasingly dependent on foreign loans. Political instability in 90s along with poor management of economy, affected family incomes negatively and the country witnessed an increase in poverty levels.

At present, the poverty scenario in the country presents a gloomy picture: 38 per cent of total population is living below poverty line, i.e., has average family income below Rs. 3000 (about 52 Euro) per month; 62 percent of adults in Pakistan cannot read or write, while 76 percent female adults are illiterate and 8 million children are out of school; 45 percent of population has no access to safe drinking water, 40 percent have no access to basic health services, 53 percent of population has no access to sanitation and 38 percent of children under 5-years are malnourished. Rapidly increasing poverty, economic insecurity, deprivation and stress are all affecting millions of Pakistani families everyday. One in three families is living in poverty. When it comes to families with children suffering from disabilities, the situation is even more disappointing and heart breaking.

Condition of Disabled Persons: In 20 years of my professional life, I have seen that persons with disabilities lack even the basic rehabilitation services, they are unable to get rehabilitation appliances or are unable to get their appliances repaired, they lack education, they have very minimal chances of learning any skills, they have no jobs, most can never get married or get a chance to raise a family, due to lack of money. There are groups of people, and there are persons, who would like to form groups work for their own welfare on self help basis, but most of them lack resources and so can not participate in their duty towards national development.

People get sick, remain ill and even die, as they do not have enough money for their health care. Their families watch their beloved ones, slowly getting close to their graves, with open helpless hands. Sometimes they do not have money to buy even a pain killer.

People with physical disabilities sometimes develop contractures, as they do not know that simple little exercises everyday can prevent its formation. The contractures deform their joints, stop them from walking, make them remain sitting forever with no therapeutic care to regain walking, leading to formation of kidneys or bladder stones, causing infections, leading to death. A little exercise daily could have prevented this vicious cycle. Such vital information are either not available, or ordinary persons, poor persons do not have any access to such information.

Spinal cord injuries are one of the main causes of urinary tract infections, the biggest reason of deaths among such persons. There are thousands of persons having this injury every year, but proper management and care is expensive. They often sell their cattle, land, house, and even children to get some rehabilitation care.

A strong network of rehabilitation centres through out the country can be a big help. Big cities provides such commercial, on-profit services, but those services are not for poor persons. In a big city like Karachi with a population of 11 million, there are very few places where a poor child could get rehabilitation services on low-cost basis. Parents have to take loans and sell any expensive things that they may have in their homes to pay for their child's rehabilitation. Thus the parents get themselves involved in a vicious cycle of ever increasing poverty and decreasing power to meet their family needs.

Poverty in Northwest Province: Generations after generations, people never get out of this cycle of poverty. That is why poorer families are getting even more poor. Persons and families already suffering, suffer even more everyday, especially when they

are from any disadvantaged / marginalised group.

In our province, Northwest Province, the population is 22 million. Poverty affects every aspect of life here. If men work to earn daily living, women cook, wash, clean, take care at home and also fetch wood and water for daily use. A common tradition is to have large number of children. Increasing poverty forces the family elders to put children to work, in the fight against poverty, as child workers instead of getting education. So these children, instead of having a school bag, books and copies, work as rag pickers, shoe polishers, car washers, motor mechanics, house maids or even beggars from a very young age. Generations are being getting affected by poverty, with helpless and hopeless parents reach their graves, passing their whole lives in trying to make both ends meet in their fight for survival.

One of the solutions to alleviate poverty lies in bringing structural reforms in the economy and rural society to break the hold of feudal-groups on the state power and liberate the masses and economy from their clutches. Government must ensure that poor people are able to obtain basic services. Otherwise, it would be reckless of us to successfully reach the Millennium Development Goals in 2015, only to be confronted by dysfunctional cities, dwindling water supplies, more inequality and conflict, and even less cropland than we have now to sustain us.

Considerations on Gender issues in Pakistan:

Article 25 of the Constitution of Pakistan, in the Chapter on Fundamental Rights of the citizens say 'There shall be no discrimination on the basis of sex alone». Quid Azam Muhammad Ali Jinnah, Father of our Nation, in one of his speech said: "It is a crime against humanity that our women are confined within the four walls of their homes like prisoners. Women should stand side by side with men as their companions in all aspects of fife".

After these two very quotes about status of women in Pakistan, let me briefly talk about the actual conditions faced by women in Pakistan. Women, like in most societies of South Asia, are considered inferior to men - physically weaker, mentally less endowed and created only to serve the household. This classical image of women keeps her illiterate, economically unrecognised, socially inferior and legally helpless. The social distortions of male dominated society have created mind sets so that people firmly believe that women are meant to serve the men. This is true not only among lower strata of society or in rural areas, but it is also true at higher levels in feudal and tribal cultures in Pakistan.

In most families, especially in tribal and rural areas, women do not get the right to choose their life partners – the choice is made by parents or family members, on the basis of family relationships or money. After marriage, life in the joint family means that women have to cook, wash, press clothes and do other household chores, not only for their husbands, but also for their husbands' families, so that their role is that of maid-servants. For the marriage they are also required to bring expensive dowry from their parents' homes.

In rural areas, a woman is expected to work in the fields along with her husband and also to cook, give birth to children and to look after all their needs till they grow up. In some areas of the country, sending girls to schools is regarded as a sin. If a woman has no child or has no male child, she is considered almost as an outcast and her

husband can be persuaded or forced by his family to bring another wife.

Even the societies, where women have been ostensibly helped by enactment of modern legislation, in reality, they situation remains as depressed as ever. Pakistan is a good example of the tricks played upon women in the name of law. Even where the laws are forthright, women are denied their benefits due to momentum of traditional norms, beliefs and customs, and lack of facilities, which could create confidence and daring among them.

Above all other issues is the tyranny created by the religious leaders (Mullahs), which force women to be prisoners inside their homes. The *hudood* and *zina* ordinances are examples of laws damaging the women. Thus, victims of men's assault have been punished by the courts whereas, the culprit men have usually escaped without any punishment. According to a survey report, almost one third of women in jails in Pakistan, are there because of these ordinances. These laws also become a blessing for men who, for example, do not wish to give share of the ancestral property to their sisters and daughters. Women are also utilised to pay *dyat*. Moreover, one third of women in jails in Pakistan are either convicted or under trial on similar charges. Many of them with their children.

Most of the socio-cultural traditions are largely discriminatory against women causing serious problems ranging from inferiority complex to narrow mindedness, helplessness and insecurity among local womenfolk. Millions of women are mutilated, battered to death, burned alive, stripped of their legal rights and bought and sold in an unacknowledged but international trade as slaves for domestic or sexual purposes.

There are barriers against women involvement in decision-making and realisation of all human rights and fundamental freedom of women. There are discriminatory attitude against the neglected half of human population, at official and individual levels. Women are the one to sufferer most in all conflicts, suffering violence in the form of rape and displacement to the denial of the right to food and medicine.

Honour killing, violence and sexual abuse, acid violence, forced marriages, involuntary virginity tests, female genital mutilation, trafficking and forced prostitution, and other crimes are often culturally sanctioned homicidal violence directed at women and girls around the country. Due to deep rooted male chauvinism that has been dominating our country since long before independence, the plight of our women remains as pitiable as ever. Stoves still continue to burst and the clothes of young brides continue to catch fire while working in their in-laws kitchens, because the brides were unable to bring a big dowry. Stone hearted husbands are still busy torturing their wives in the most inhuman manner, and often getting away with it . Eve teasing is as rampant today, as it was fifty years ago when the nation was composed of 100% illiterate persons, be it in cities or in rural areas.

The poorest, the most illiterate, the most malnourished, the most deprived, most of the Pakistani women have no right to live according to their own choice. They also suffer from killing in the name of honour by *Karo Kari*. The "honour" killers escape punishment easily due to loop-holes in the law, or because society allows them to do. It is considered that they have no right to choose their life partners, which Islam gives to women to choose their spouse. It also gives her right to separate or divorce her

husband, but our society deprives women of these fundamental rights.

A continuous struggle is needed for recognition of women's rights as human rights, including their civil, social political and cultural rights. Attainments of all these rights is critical for achieving human development in general and more specifically, women development. To ensure this, there are some prerequisites - a just legal system, inclusive democracy, poverty eradication, data collection on the state of women development and women rights, violation, an active media and an NGO/ CB0 sector generating awareness, and stronger international actions, etc., are needed, which are quite poorly rated in Pakistan. On the other hand, Islam advocates rights of women and requires that they are given a respectable status in the society. Islam is the promoter of women's respect and honour and the problems of today's women are the result of deviation from the Islamic principles.

Let us see the efforts being taken to solve some of these issues. The National Commission on the Status of Women has been established by the Government after 53 years of independence. The commission is supposed to review and amend laws, rules and regulations that affect women's rights, examine the polices for women development and make recommen-dations for its effective impact and im-plementation. It will also work together with national and international NGOs with common agenda. Many NGOs are already active in Pakistan regar-ding women development issues.

The previous Governments had also initiated small things related to women's rights, here and there – women's police, women's banks, crisis centres, women's division, etc. But most of these remained only promises or just policies on paper with little of it being translated into reality. We can not solve the problems of all Pakistani women with one formula, as they are different in class, region, ethnic background, religious beliefs etc. so the solutions must also be different.

Development Programmes: In Pakistan, women's development programs have to be defined within the parameters of Islam and the existing social and traditional values – keeping these in mind, specialised development programs need to be worked out. However, the entire effort is dependent on building and strengthening human capital by investing in health, education and provision of a fair playing field for all citizens of Pakistan. Women, like men, are part of a society and to expect to transform the lives of the women without reforming and investing in the whole society will not be possible. The Government should also prepare a national policy on gender on a priority basis, and pursue realistic, achievable goals to solve this critical and urgent issue.

We are also running a group of women with disability called POWER (Promotion of Women Empowerment & Rehabilitation), working in seven towns of Pakistan and addressing different issues.
These groups provide technical skills and help them in understanding and solving their own problems by building consciousness, self-confidence and leadership qualities. As Dr Mahboobul Haq said, "No nation can develop if it is half-chained and half-free. Empowerment of women through their full participation in education, employment and political & social life is vital for development. ■

Health for All Through Leadership & Social Conscience*

Halfdan Mahler

I have always maintained that people's own creativity and ingenuity are the key to their and the world's progress. People's apathy can turn development dreams in to stagnating nightmares. The transformation of social apathy into social and economic productivity is the point of embarkation of all human development. And an adequate level of health is a basic ingredient in generating the energy that fuels this transformation. Development is, in the final analysis about human aspiration, and the individual's realisation of his or her potential. What billions of people throughout the world need and want is what everyone everywhere needs and wants: the wellbeing of those they love; a better future for their children; an end to injustice; and an enforcement of hope.

So development everywhere is about the creation and expansion of opportunities for human beings to realise what they consider to be their positive destiny. It is a complex and messy process involving the interplay of physical, socio-economic and political variables. And we are not talking about dealing with physical sciences and controlled environments where quantifiable elements can be introduced and results predicted. We are talking about human expectations, perceived rights, preference values, and people's emotions and attitudes about those rights and values.

Equity, especially in ensuring essential health and socio-economic needs, and particularly as it relates to vulnerable groups such as children, women and the disabled, remains for me a pri-mordial objective of all development. I believe that a greater degree of equi-ty, to assure a more just and reasona-ble equality of opportunity, is an ab-solute necessity of a sane humanity.

There are one billion humans caught in the absolute poverty trap – a condition of life so characterised by malnutrition, illiteracy and low life expectancy as to be beneath any reasonable definition of human decency. But even such chilling statistics do not paint the true picture of relative affluence and poverty, the chasm that exists between what Cervantes called the "only two families in the world – the Haves and the Have-nots".

Leadership And Social Conscience

How, then, in an environment of gloom and doom is "social conscience" on the part of leaders generated? Rarely in history has this kind of leadership been so essential – so vital; leadership to propagate new values in the society, particularly values that are concerned with social progression; leadership of democracy, of involvement, of responsibility, of objectivity and of compassion.

Leaders have a significant role in creating "the state of mind that is the society". They can express the values that hold the society together. They can bring to consciousness the society's sense of its own needs, values and purposes.

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* Excerpts from speech at AIFO National Conference, October 2001

It is my firm personal conviction that leadership is nothing if it is not linked to the collective purpose of the society. The effectiveness of the leaders must be gauged not by their charisma, or their visibility, or the so-called power they hold, but by the actual social change they create, measured by the satisfaction of human needs and expectations. I speak of moral leadership, where values have a decisive place, where leaders assume consummate responsibility for their commitments, and thereby produce social change that is relevant to the needs, aspirations and values of the society.

The world's health conscience was shaken by inequities such as the ones to which I alluded earlier quoting Cervantes. This lead WHO's supreme organ, the World Health Assembly, to decide in 1977 that the main social target of governments, peoples and WHO in the coming decades should be the attainment of what is popularly known as "health for all". And the Health Assembly described that as a level of health that will permit all the people of the world to lead socially and economically productive lives. Please note that the World Health Assembly did not consider health as an end in itself, but rather as means to an end. That end is human development as characterised by social and economic productivity. You will also note that the social aspect of development preceded the economic aspect. That is as it should be. When people are mere pawns in an economic growth game, that game is often lost for the underprivileged as so vividly seen in to-days globalised casino-economics.

By adopting the **Global Strategy for Health for All** in 1981, the World Health Assembly heralded a new era for health, which called for a morally binding social contract between peoples, and their representatives at local, national and international level. This social contract, commonly known as the Primary Health Care Strategy, implied a commitment not only to a reorientation of the health care systems – better called medical repair industries – but to a shift in people's own control over their health and well-being to the extent that they would be able and willing to handle profound social reforms in health.

The terms of this social contract were enshrined in the fundamental policies for Health for ALL:

- Health is a fundamental human right
- Health a world-wide social goal
- People have the right and duty to ensure their health care
- Governments have responsibility for the health of their people
- People's health is an integral part of overall development
- Countries must eventually become self-reliant in health matters
- The existing gross inequality in health must be drastically reduced by the end of the millennium
- Optimal use must be made of the world's resources to promote health and development

The next question was how to make these policies more tangible. This lead to identifying a number of pillars on which policies like these could rest:

- Political commitment
- Community involvement
- Intersectoral action
- Appropriate technology for health
- Development of appropriate health manpower – technically competent and socially motivated
- A sound leadership and managerial process

I do believe that Health for All is still a popular social concept, and promoting it is therefore a profitable political investment. So it does become useful as a platform for political and other leaders to promote equity and social justice. Community involvement is not just a case of people doing what the governments tell them. It means people taking an enlightened self-interest in their own health - doing what they can to promote and sustain it - and making intelligent demands on their elected representatives based on a proper understanding of what is technically, socially and economically feasible.

Leadership Development And Health For All

It can readily be seen from my earlier comments that the strategy for Health for All encompasses fundamental change in the way health is perceived, promoted, protected and provided. It implies a commitment, not only to a reorientation of the health care system, but to a paradigmatic shift in people's control over their own health and well-being to the extent – of course – that they would be democratically willing to do so; a social reform which truly empowers people in matters of their own health and well-being. Such a strategy for change can only be propagated by leaders, because I believe that the most important function of leadership is achieving change, and, in the context of moral leadership, achieving change for a collective purpose of the society.

I believe that leaders are there, who are willing to take up this challenge; able to visualise the scope for improving human conditions and thus willing to focus their intellectual and moral energies accordingly, and also to motivate others, especially the future generations of leaders towards these new social values. In short: they are YOU – now and here! To these leaders, equity must remain a primary concern, particularly in meeting essential health and socio-economic needs. I would like to sketch some key qualities for leadership for Health for All:

- A clear understanding of the Health for All strategy;
- A commitment to guide international, national and local policy decisions towards social equity, among people;
- A comprehension of the health aspects of policies of other sectors;
- A capability to identify critical issues affecting the implementation of HFA strategy;
- A confidence borne of knowledge of having relevant skills and experience;
- A capacity to motivate others.

The most important attribute of leadership to my mind, then is vision because visionaries are the true realists of humankind's history. Because of focussing attention on a vision, such leadership operates on the intellectual, emotional and spiritual resources of the group – whatever the group may be – and on its values, commitment, hopes and expectations. So, by communicating the vision to others, your leadership is actually appealing to some of the most fundamental human needs: to be important; to make a difference; to be useful; to be part of a worthwhile successful undertaking – not only doing things right, but doing the right things.

Your leadership therefore, is and will grow into a vital ingredient in achieving the goal of Health for All and today its influence is urgently needed at all levels of the society. Changing the existing established health systems, institutions and bureaucracies

without threatening unduly the existing power structures is perhaps the most critical issues facing political, social and intellectual leaders pursuing the vision, values and goals of Health for All. Few positive changes are evident today, even though there are dedicated leaders who are trying to do so. There are both methodological gaps as well as attitudinal constraints with which to contend. There is particularly the leadership gap in the health sector itself which limits the understanding of the nature of the change required, the value of such change and the process of change.

There seems to be little if any change, in the attitude and commitment of health professionals, and particularly the medical profession. In most countries there seems to have been insufficient and unsatisfactory dialogue between the agents of change – the leaders – and the health professionals, on the need for the process of this radical change.

The educational and scientific institutions, which should prepare and guide the health leaders of tomorrow have only responded marginally to the challenge posed by Health for All.

Admittedly, **health leadership development** is a complex and messy issue. We have only just began on this long journey of achieving changes – some of which challenge the roots of our long-established traditional systems, service systems, educational systems and research systems; many of which appear to have outlived the usefulness for the purpose for which they were created.

The question has been asked: "Can we afford the cost of social justice?" The costs generated through the creation of a just and equitable health care system may indeed cause some economic turbulence. But equitable cost containment measures, combined with judicious cost recovery, can be introduced and resources can be reallocated. Social justice and fiscal responsibility do not have to be incompatible. They will be only if there is a breakdown of political nerve.

If present inequity trends continue undiminished, the world will be more crowded, less stable ecologically, and more vulnerable to socio-economic and political devastation. I believe the most turbulent transition will be that associated with the establishment of equity between all ourselves aboard spaceship EARTH. The word inequity is so close to the word iniquity, which means SIN. But, I also believe that Health for All is one of the major genuine social revolutions of our times. Health for all leadership has the powerful potential for improving the quality of life for hundreds of millions of people who are, through no fault of theirs, subjected to gross socio-economic injustices. Such leadership is moved by a vision which cannot tolerate the unacceptable inequities of life, and which has faith in the potential of people, in their inherent ability to develop and to be responsible for their own destiny. We all have to practice the spirit of the old saying:

> "Go to the people
> Live with the people
> Learn from them
> Love them
> Start with what they know
> Build on what they have
> When the task is finished, the
> people will say,
> We did it ourselves!"

Moving towards the end of my remarks today I would like to repeat the concept of **Primary Health Care** as contained in the **Declaration of Alma Ata**: "Primary Health

Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process". And let me add that primary health care includes at least: education concerning the prevailing health problems and the methods of preventing and controlling them; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

The fight for social justice can often be frustrating, since development knows no limits, and the more you move up along the road, the more you want to move. You cannot blame people if they strive to join up with those who are further along the road than they are. That is only human nature. Injustices however have to be seen through the eyes of who are farthest behind on the road. We must not let these injustices take over. This injunction should be the moral vision for the future ahead of us. ■

Accessibility of Health Services in Nepal

AAKASKO PHAL AANKHA TARI MAR - WATCH THE FRUIT IN THE SKY AND DIE

Sarmila Shrestha

Introduction:

Nepal's health care system has been more of a myth than a reality for the poor people of Nepal. They hear about the government's plan and about the large amounts of money spent on health care, however, thousands of poor people continue to suffer and die of conditions like diarrhoea, dysentery, common cold, pneumonia, encephalitis, meningitis and other treatable illnesses. The government's slogans exclaiming, "Health for all by 2000", and "Primary health care as people's rights", are used to attract donor support, but these programs are not actually implemented. For this reason, Nepal's health care system has become inaccessible to poor people. Poor persons see the hospitals and health-posts but they can not afford to buy the services or they are afraid to approach or they do not find any health personnel or medicine when needed. Rural poor people have been accepting this situation, as their "fate" or "destiny" or "karma".

Women Acting Together for Change (WATCH), a Nepalese NGO for which I work, strongly feels that there is no commitment from either Nepal's government or from so-called international agencies to reach the poor and to provide them with basic health services. The structures and facilities created by the government agencies do not allow them to reach the poor and to understand their needs and interests. How can they see, what is happening with poor people while they travel by planes or jeeps, and stay overnight at luxury hotels and lodges? They have no direct contact with the people they are supposedly trying to help.

WATCH therefore strongly advocates against the present health care system in Nepal and advocates for an alternative system that can be managed by local health-care users themselves. WATCH also feels that without impro-vement in other sectors like literacy, awareness, decision-making rights, livelihood, rights over resources, etc., it is almost impossible to make any improvements in the health sector alone. Based on this premise, WATCH has been trying out an alternative health care system in three districts of Nepal (Okhaldhunga, Rupandehi and Chhaimale in Kathmandu) for the last eight years with support from AIFO. I will be making a presentation based on this experience.

Background:

Nepal is a sovereign, independent, democratic and landlocked country with a constitutional monarchy. It is a country renowned for Mount Everest, Buddha's Birth Place, and Community Forests. Its population is estimated at 22 million. It is one of the poorest countries in the world with a per capita income of US$240 per year. More than 60% (42% according to the government estimate) of the population still live in abject poverty, which affects all sorts of human development indices. For example, Nepal's level of health is indicated

by a relatively high infant mortality rate (64.14 per thousand), child mortality rate (105.44 per thousand), maternal mortality rate (6 per thousand), and the average life expectancy (58 years). Diarrhoeal diseases (15%) and TB (4-5 per thousand) are major killers. Malaria continues to resurge, and encephalitis, meningitis and kala-azar (Visceral Leishmaniosis) are reaching epidemic proportions. The prevalence of leprosy remains one of the highest (3.2 per thousand) in the world. HIV/AIDS and sexually-transmitted diseases (STDs) are expanding without any checks, despite the government's claims of investing in "health care for all".

In all of Nepal, there are 83 hospitals, 13 health centres and 275 ayurvedic hospitals with a total of 5190 beds. As well, there are 711 health posts, 160 primary health centres and 3179 sub-health posts. In terms of health care providers, there are 1259 doctors, 4655 nurses, 421 vaidyas (Ayurvedic doctors), 5295 health assistants, 3190 health workers, 4015 local health workers and 62,546 birth attendants and female health volunteers. The government is allocating a budget of US$ 57-60 million annually for health care services, however, does this level of investment reflect effective or accessible health care?.

How Accessible are Health Care Services?

The government's annual expenditure for health care services is US$ 2.5 per person. Most of this money is spent on infrastructure development and salaries. The rest goes to hospitals, health centres and health posts that are not within the reach of poor people. There is no special program or expenditure to reach real poor and people in remote areas, who really need medical services.

On average, one hospital bed is available for 425 people. In terms of human resources, there is one doctor for 1750 people, one nurse for 473 people, one Vaidya for 5225 people, one health assistant for 415, one health worker 315 people, and one health volunteer for 35 people. It looks quite impressive but let us look at the reality in terms of accessibility for the poor and people in the remote areas. Doctors, nurses, and vaidyas are available only in cities and metropolitan areas; even hospitals and health centres in outlying district centres are without them. Even if they are available, their fee just for investigation may cost around US$ 2, which is almost the equivalent of three days wages. Health assistants and health workers may visit their posts but they will stay there for not more than six months. They also charge fees for investigation, which may cost their patient's around one day's wages. Furthermore, health posts are supposed to distribute free medicines but medicines are not usually available unless one decides to buy from them. Even honest workers have difficulty, because the medicine provided to them is not enough to last three months. Thus, health posts are also not accessible to poor people and have not been providing services to people in need. There are quite a lot of health volunteers, but they are trained only for about five days and they are not given any materials and medicines. Every year they are provided with five days refresher training, however, they have not been able to provide services to people, due to the lack of proper training, information and medical equipment. Consequently, they are losing their credibility and usually poor people do not visit them or trust their advice.

Regarding affordability of health care provision, as already mentioned, almost 60% of people are below the poverty line,

who live a hand-to-mouth existence. In Poor and remote areas, persons needing health care services, have to travel long distances, which is costly and time consuming. Thus they must forgo the wages they could have earned during this time, which is necessary for their own survival and that of all their family members. If poor persons become sick, they are often forced to sell whatever property they have or become indebted for life. Once they manage to reach the health services, usually they are not properly dealt with and may be blamed for late coming or humiliated for their ignorance. They may have to wait for hours and spend hours trying to figure out the procedures. As most of them have not seen or experienced such services previously, they usually need to go through a thorough investigation, which costs quite a lot of money. Then they have to start paying for beds and medicines. How can a poor person afford to pay for such services? All the health-care measures are geared towards providing services to rich and elite but not to poor persons and persons coming from remote areas. So most of them do not get an opportunity to see any health services, and die without knowing what killed them. Sometimes, they are asked to go to the private clinics owned by hospital authorities. Even if admitted, they have to buy medicines and sometimes even food. Some hospital beds are quite expensive. Thus, hospitals and hospital beds are not for poor and needy people.

Let's look at the situation, particularly at the distribution of medicines. Medicines are quite expensive and many of them are either fake or low quality because of a systematic lack of standards for monitoring. To make matters worse, people are not given proper advice for taking medicine and they do not take the full doses, prescribed to them. As soon as symptoms disappear, they stop taking the medicines and so by the time they visit the hospital, their illness has usually progressed into a sort of terminal case, requiring special and lengthy treatment.

The above scenario portrays the reality of the situation. The poorest communities have no time to report about their poor health and miseries, even if most of them have at some time of their lives, been the victims of various diseases.

For example, almost all women have usually suffered from various sexually transmitted diseases. Lack of adequate food does not allow people to grow and develop physiologically properly. And their lack of knowledge about health, hygiene, and environmental sanitation does not help them to live healthy lives. Even if they have some knowledge and awareness, they cannot practice them because of lack of time. Lack of money does not allow them to get proper treatment for any kind of diseases. The health messages prepared by centralised health services are often not relevant to their local conditions and are not understood by them.

What is WATCH Doing?

As WATCH works with the poorest and most disadvantaged groups, it recognises that women are treated badly in the household as well as in the society. They lack self-esteem and self-respect. They are resource-poor and usually need to work hard for their survival, from the early morning to late in the evening. In fact, they do not have time to think about "development". They are used as vote banks and their votes are bought by political leaders. Looking at this situation, WATCH identified the poorest and most disadvantaged women in the villages and began building a rapport with them.

Gradually, WATCH helped to organise themselves in groups, to build their confidence and self-esteem, to understand their struggle and situation with empathy, and worked to raise their awareness regarding their rights and responsibilities.

WATCH also helped these women's groups to develop their own plans, to involve them in communal activities, and to help them assert their rights with various institutions and organisations through a federation that serves as a lobbying force. So-called poor women's awareness is raised through functional literacy, regular interaction, meetings, and awareness raising camps, various training courses and involvement in decision-making of their own activities.

Gradually, these women have felt the need for taking part in the broader development context. So they are organising to ask for their share of development.

They have mobilised themselves to have their own citizenship certificates, land rights certificates, water rights, identifying common candidates for election, etc. They have started taking part in decision-making, in the implementation of a health program and in local natural resources management such as community forestry, drinking water supply, creation of irrigation ditches, etc. A few of them have been elected in the local government bodies. They are keen on safeguarding the rights of women at household level, community level and national level. However, they need continuous support, interaction, information, and morale-boosting. AIFO's support to WATCH has facilitated poor and disadvantaged women's awakening, which needs to be replicated in other areas.

Some of the activities initiated by WATCH are as follows:

Health Clinic: WATCH has established three simple clinics in three areas it has been working. They are equipped to provide primary health care services. First WATCH hired nurses to provide services, however, because many nursing homes opened in the areas, the nurses could no longer stay there. Later, health assistants and community medical assistant (CMA) were hired for running these. WATCH clinics keep family folders, health records and provide free primary health care services.

Mobile Health Services: As rural and poor people are quite busy, if services are not provided nearby, they will not be able to use those services. For this reason, WATCH has divided its area into various clusters. WATCH staff and health volunteers visit these clusters once a week, to provide primary health care services, and to discuss health and sanitation issues. This way people do not have to lose their wages for visiting health services. Local women's groups help manage such services.

Awareness Raising and Service Camps: WATCH has been conducting awareness-raising campaigns and service camps for activities like deworming (every six months), providing medical services, initiating dialogue on environmental sanitation, balanced diet, HIV/AIDS/STDs and their prevention, against women trafficking, etc.

Non-Formal Education: WATCH has been conducting functional literacy classes (20-25 every year) based on key-words methodology. Some of the key words relate to health, sanitation, sexually-transmitted diseases (STDs), HIV/AIDS, nutrition and balanced diet, etc. WATCH also conducts a one-day training course to make literacy facilitators capable of using a package of awareness-raising materials on HIV/AIDS/STDs and girls trafficking (provided free by WATCH).

Awareness and Support for Inoculations: The government and other agencies are providing various vaccinations and inoculations. As they do not have sufficient human resources for publicising such services, WATCH helps them by discussing their services in women's groups meetings, encouraging women's groups to take part and assist in publicising, providing venues and keeping records.

School Health Program: WATCH also provides services to local schools for regular health check-up of students, for taking health and sanitation related classes, and providing necessary materials and services.

Health Volunteers: WATCH has been training local women volunteers selected by women's groups for providing first aid services. For example, they provide some simple medications for headaches or making "Jeevan Jal" (rehydration solution). The volunteers also work as birth attendants, provide information about health, sanitation, nutrition, cooking vegetables, and "Sarbottam Pitho" (multi-grain flour). They also encourage and assist people to make simple latrines, smokeless hearths, and kitchen gardens. They provide services for children to bathe, cutting nails, cleaning yards, making wastebaskets, etc. WATCH provides them with modular training, medical kits, basic medicines and regular supervision. They also help WATCH during camps and campaigns. These volunteers charge a nominal fee for their services and they also get 50% of charges raised by the women's groups or federation for health services.

Health Care Fund: WATCH provides medicines and medical services for free, but the women's group's federations charge a nominal fee for making family folder and cards (Rs. 2 or about 3 cents), for health services (Rs. 2 or so for each visit), and for the sale of medicines other than essential drugs (at Kathmandu rate). By now each federation has collected quite a substantial fund. When WATCH decides to hand-over clinics to the federation or communities, WATCH is also planning to contribute the amount necessary for the sustainability of the clinics.

Health Management Group: Women's federations have Health Management Groups selected to look after and manage health care activities. They are slowly being trained to take over the management of health care services in the area. As they are poor and newly literate, it is taking more time than expected.

Organisation of Service Seekers: Local women as health service users are organised to seek services from governmental and non-governmental agencies. Similarly, sex workers or HIV positive persons are also organised to seek services. They are organised with a hope that they would not feel marginalised from society, and that they would feel as useful members of society and fight against discrimination.

Integration with Other Activities: WATCH is involved in various activities as demanded by local women's groups. All its activities like agriculture, horticulture, livestock improvement, natural resource management; women's empowerment, etc. are integrated for the improvement of people's livelihood with the goal of living life with dignity.

Conclusions:

Nepal is one of the more impoverished countries, where the status of women is very low, where support and services for women is negligible, and where awareness about women's rights and responsibilities are dis-

cussed only among the educated elite. Thus rural women in Nepal are very much suppressed. They are kept out of the development dialogue, and the struggle for their livelihood does not allow them to take part in social development. WATCH, with support from AIFO, has been working in three areas of Nepal with most disadvantaged and poorest women groups. Gradually, these women are taking their own awareness and development in their own hands through organising and federation building. Women have been active in seeking health services and slowly stepping ahead to manage health care activities. This support has helped WATCH to work out processes and approaches that contribute to women's empowerment, awareness raising, so that they can take control of their lives and provide the necessary services including primary health care within their own communities. By working together, WATCH has created an enabling environment to organise the poorest women, who are aspiring to take part in a broader development context. ■

Rich & Poor Theories of HIV Transmission

Stephen F. Minkin

Chinua Achebe, the Nigerian novelist, made this bitter observation about Dr Albert Schweitzer in an essay entitled "*An Image of Africa*":

> *Schweitzer says: "The African is indeed my brother, but my junior brother." And so he proceeded to build a hospital reminiscent to the needs of junior brothers with standards of hygiene reminiscent of medical practice in the days before the germ theory of disease came into being*. (1)

When it comes to international efforts supporting AIDS prevention, Africans are often still seen as junior brothers and sisters for whom the germ theory of disease only applies to their sexual organs.

The United States and Western Europe has been most successful in fighting AIDS by preventing the spread of HIV infection at hospitals and clinics. We invested heavily in universal precautions, reduced the use of transfusions and screened all blood and blood products for HIV. In contrast many countries are advised to skip this step and go directly to sex education and condoms. These too are valuable tools but it is hard for me to understand how AIDS prevention will be effective without investing in harm reduction in the provision of medical services. HIV is a germ carried by blood and lymph as well as semen. This is as true in Africa as it is in Europe and North America. Effective HIV prevention must include harm reduction within all areas of the health sector.

What are we to make of the fact that World Bank and UN personal are advised to bring their own disposable syringes in areas with high prevalence of HIV but clean syringes are not a priority for the World Bank and UNAIDS prevention. Does this not stink of the junior brother and junior sister mentality? To what extent do such attitudes perpetuate a relativist germ theory of disease and thereby reducing the effectiveness of AIDS prevention and distorting the research agenda?

Imagine AIDS in the United States or Europe if we had ignored the potential for hospitals and clinics to become centres of HIV infection. Suppose we highlighted condoms and sex education but were haphazard in the application of universal precautions and blood screening. Suppose our hospitals and clinics played viral roulette by sometimes using sterile equipment but often reusing unsterile syringes needles, catheters, specula and other invasive equipment over and over again. Under these circumstances AIDS in the US and Africa would look more similar. The rich countries would have an overwhelming health problem, with large numbers of women and children dying from AIDS.

Many people in developing countries face the daunting task of preventing AIDS without any certainty that the doors to the medical transmission of HIV have been closed. Data on injections, obstetrics including abortions and other nosocomial routes of transmission are remarkably absent given the huge

number of invasive procedures in areas with high prevalence of HIV.

After two decades we still have much to learn about HIV transmission and prevention. In 1999 a large prospective study in Africa on the relationship between STDs and HIV was conducted. The results, in Rakai, Uganda, were not as expected. The overwhelming majority of "HIV seroconversion occurred without recognised STD symptoms or curable STD detected by screening."[2] The Uganda research follows earlier studies showing that many or most HIV-positive women at outpatient maternity clinics had no previous history of sexually transmitted diseases. Such findings run con-trary to the viewpoint that promiscuity alone account for the fact that Africans are so vulnerable to HIV/AIDS.

Surely, AIDS is sexually transmitted in many parts of Africa, but as in the United States and Europe there is much more to the story than sex alone. The incidence of blood borne HIV is greater countries where women start childbirth early and have closely spaced pregnancies. Demand for blood to treat obstetric emergencies and pregnancy-related anaemias are a vexing problem where the prevalence of HIV among blood donors makes safe blood a scarce and rare commodity.

Pregnancy-related anaemia is most serious in areas with endemic and epidemic malaria. Likewise prevalence of severe paediatric anaemia requiring blood transfusions, particularly in malaria-endemic regions has markedly increased along with AIDS. Women of childbearing age, infants and young children are most vulnerable to the devastation of malaria compounded by poor diet and the numerous stresses caused by poverty.

In developing countries women and young children are most vulnerable to medically transmitted HIV infections. Women of reproductive age get more injections and invasive examinations than other demographic groups. Usually they start childbirth earlier and have more children than women in the West. They need more life-saving tran-sfusions for childbirth complications and for pregnancy-related anaemia. They are also placed at risk because of medically questionable injections and transfusions. A vexing problem is to ensure that they get blood when they need it without exposing them to HIV, Hepatitis B or C, and other diseases. This will require investments in training, salaries and equipment.

In the US and Europe the greatest risk of HIV infection for heterosexuals is among people using unsterile needles or women whose sex partners use unsterile needles. In the US people infected by needles are called "junkies" or IV drug users. In other parts of the world they are often called patients. The October 1999 World Health Organisation Bulletin reported that over 50 percent of injections were unsafe in African countries for which data was available.

UNAIDS estimates that 5-10 percent of global HIV infection burden is directly related to blood. That means millions of infections are at issue. Even if we accept these minimal figures, their significance for AIDS prevention in developing countries is much greater. Investing in AIDS without plugging this hole is like pouring water in a bottomless bucket. Without safe health care, much of the future spending on AIDS will be both ethically dubious and ineffective.

For centuries the West has exploited Africa's human and vast natural resources. Europe and the United States have most often been

behind much of the violence and war that have plagued and ruined much of Africa. It is now time to make things right. One important step is to support an alliance ensuring that no woman, man or child is infected by HIV when seeking health care. Here is part of a message I received recently from a friend working in Uganda:

> *"The one unfinished research item on the HIV transmission occurs in places such as Mulago Hospital where 70 deliveries are done daily, sometimes without access to running water and without rubber gloves for the midwives. Mulago is the best and then when you think of rural hospitals and how much blood is associated with deliveries and what proportion of the women are HIV positive..."*

Such issues have not been popular within the international AIDS community. I personally do not understand the global double standard. Are white people more vulnerable than brown and black people to HIV infections from blood or unsterile medical procedures?

While millions of dollars have been invested in academic studies on sex risk factors, how many studies or interventions have focused on viral loads in needles, syringes, scalpels and speculum, catheters, IV drips and multiple dose vaccines and medicine vials. We need to rule out these potential sources of HIV transmission. There is no literature on invasive medical procedures and the risk of HIV transmission in areas with high prevalence of HIV. The absence of studies does not mean that there is no problem of HIV transmission in health centres but suggests that Chinua Achebe comments are still very relevant today.

Where are the case studies of injection practices and HIV in formal and non-formal healthcare settings? What about risks associated with births and abortions in hospitals? Has anyone looked at cases of postpartum HIV to search for the sources of infections? Who has looked at surgical patients and post- operative rates of seroconversion? What about the use of specula as potential sources of HIV infection, but also as a way of transmitting genital ulcers? Has anyone clearly ruled out phlebotomy as a means of transmitting HIV? It is remarkable how little we know about these potential routes of transmission nearly twenty years after the modern AIDS pandemic entered Africa.

The myth that HIV is a fragile virus is simply not true. The virus can remain viable and infectious in both wet and dry states for many days:

> *"Solutions of HIV were analysed for the presence of infectious particles and reverse transcriptase activity after exposure to different temperatures over a three -week period. Competent HIV was no longer detectable after three to five hours at 5 °C, after 11 days at 37°C and was barely detectable after 15 days at room temperature (20° to23°C). HIV solutions that were allowed to dry at room temperature yielded infectious particles upon reconstitution between three and seven days after the initial drying.*(3)

That doesn't seem fragile to me. What I find so astounding is that most of this work was done so early in the epidemic and yet the myth persists that the virus is fragile. Next come hospital practices that increase the infectivity of medical equipment for example the all too common practice of soaking batches of syringes in weak disinfectant solutions. We know from the work on IV drug users that this is an excellent way to cross contaminate syringes. (4)

Hospital infections are a problem in both rich and poor countries. In the United States tens of thousands of nosocomial infections occur every years despite substantial resources for infection control. In Bangladesh I leaned that Dhaka Medical College has the same problem as Maulgo. 15-20 caesarean sections are performed nightly and 25-30 vaginal births. There is no soap, running water, and gloves. A senior nurse said to me the delivery rooms are "filthy" but " to our surprise Bangladeshi women do no get infections " How can poor people not get infected in an atmosphere of blood, and filth fuelled by the overuse of caesarean sections? The real message is a political one: Let the rich soak up the medical resources, and don't worry about neglecting the poor because they are not subject to the same germ theory of disease.

I have no doubt that many hospitals in areas with high HIV prevalence have excellent infection control. But at this point in the AIDS Pandemic we need to know how many do not, and why.

It is the responsibility of every government and every health facility to ensure that no child, or adult is every infected by HIV during medical treatment. It is most important to able to document the steps taken every day to meet this target along with the obstacles standing in the way of ensuring the application of universal precautions.

When I read in newspapers that billions of dollars are needed to fight AIDS, I applauded. But then I asked, " how will the money be spent"? What proportion will actually go to improving the quality of healthcare where it is needed and what will be spent in Europe and the United States in the name of fighting AIDS. One thing I am certain is that billion of dollars worth of investments in condoms and sex education alone will not solve the problem. Certainly HIV is a sexually transmitted disease and in this respect women are most vulnerable. But HIV is also much more than a sexually transmitted disease. Again it is women who are exposed to the greatest risks of medically transmitted infections. ■

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Reaching the Poorest & Disadvantaged Populations*

Thelma Narayan

INTRODUCTION

The past century has seen an overall decrease in infant and child mortality, increased longevity, the global eradication of smallpox, and the control of major infectious diseases, particularly in some parts of the world and in certain social classes. Improved socio-economic conditions and living standards, including better housing and nutrition; public health measures; education; and increased access to medical and health care, are the major causal factors. Developments in medical science and technology and important societal shifts underlie some of the changes. The latter includes participatory democracy, which has increased opportunities for previously powerless sections of society, and recognition of the basic human right to health and health care based on social justice, among others.

However at the start of the new millennium, long-standing and yet unresolved challenges remain. They include the continuing health divide between the rich and poor; between and within countries; the gap between expected outcomes and reality; implementation gaps in health programmes; and disparities in control over decision making concerning health, between the powerful and powerless.

We need to shift attention from just reaching the poor and disadvantaged, which implies merely an extension of the existing paradigm, to understanding issues of poverty, inequality and health, and to less visible yet strong, underlying societal and behavioural processes, which call for fresh approaches and paradigms. As we *'cease our endeavours for a short while, to reconsider and redefine our goals for the future'* (MMM, 2000), which is one of the objectives of this conference, we need to re-vision our understanding of 'self' as a profession and our relationship with the 'other', particularly the poor in society, recognising the deeper oneness and unity between us and them. In reaching out to the poor, and in addressing poverty, we help ourselves. From a traditionally privileged position, increasingly subject to public scrutiny and debate, the health profession can build on its strengths and knowledge base, especially with insights from the social sciences, to increase its social accountability and work in partnership with others, especially the poor, **towards Health for All, Now!** (Health for All, Now! is the slogan of a peoples health campaign underway in many countries, with a **Peoples Health Assembly (PHA)** organised in December 2000)

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CLARIFYING WORDS, RECOGNISING SHIFTING BOUNDARIES

The Poor – Social Minority or Majority?

Critical to the theme of this paper are perceptions of the poor, and their role or agency in transformatory, change processes, towards better health and life in all its fullness, as participant key subjects, rather than objects. The word 'marginalised' is often used alongside 'poor and disadvantaged'. This suggests small numbers or minorities at the margins of mainstream society, who are left out and need to be reached. Knowledge, gained through research and experience of working outside hospitals, suggests that numbers are much larger, comprising perhaps the social majority. 'Impoverishment', another word, suggests that social and political processes occur, making people poor.

Measuring the magnitude of persons living in poverty, through poverty lines, is dependent on how poverty is defined. Income poverty or food poverty lines (measuring purchasing capacity for basic caloric requirements as in India) represent a minimal, static and even arbitrary approach, resulting in lowered estimates (Ghosh, 1990). The basic minimum needs approach (including requirements for clothing, shelter, medicine and schooling) and the Physical Quality of Life Index (PQLI) are other instruments. More recently the multi-dimensional Human Poverty Index (HPI) is a composite of longevity (life expectancy), knowledge (literacy), economic provisioning and social inclusion (employment) (UNDP, 2000). Distributional disparities occur between gender, rural and urban areas, region, ethnic and language groups. Incidence and intensity of poverty varies. Those just above the poverty line, fall below it during periods of illness, in adverse seasons, during natural calamities, social and political unrest, conflict etc. The gap between rich and poor is widening in countries where economic liberalisation is underway (PHA, 2000). While absolute poverty with a lack of resources, necessary for survival, is associated with poor health, evidence from U.S.A. and U.K. indicate that relative poverty, defined in relation to average resources available in a society, is also a major determinant of health (McCally, 1998). While the poor are sub-classified into being destitute, very poor, very poor and poor, ill health lowers access to good quality health care, and ill-treatment by health providers, are common experiences for the entire group.

Poverty is also defined in contemporary times "as the denial of opportunities and choices most basic to human development – to lead a long, healthy and creative life, and to enjoy a decent standard of living, freedom, dignity, self-esteem and the respect of others" (UNDP, 1997).

Given the broadened definitions, which are required when using a value base of social justice, there is evidence that a substantial proportion of the global population, live in poverty, with different degrees of deprivation, alienation and social exclusion.

In India, the proportion below a minimal poverty line declined slowly from 50% in 1951 to 35% in 1994, but due to population growth (which is also dependent on social development), the actual number increased from 164 million to 312 million. Recent surveys of rural households show 68% as landless wage earners and 45% of households without anyone literate (cited in Lamba, 1999). In 1998-99 in India, among children under age three, 46.7% were

underweight (weight for age), 44.9% stunted (height for age) and 15.7% wasted (weight for height) (NFHS 2, 2000). Among women aged 15-49 years, 51.8% were anaemic (*ibid*.).

This evidence along with several other studies, indicates that a much larger proportion of people suffer from deprivation, be it food, education or biological poverty, than indicated by income poverty lines, which are now below 30%. Thus it is suggested that the poor in India and globally comprise a social majority (Pinto, 1998).

Does this make a difference to our strategies?

What is being reached – Health and/or Medical care?

Increased provision of medical care reduces unnecessary pain and suffering, but in itself only marginally improves health status. WHO defines health as a state of physical, mental and social well being, and not merely the absence of disease or infirmity. Attempts to improve health status, towards reaching this ideal, have long recognised the importance of access to basic determinants of health, such as nutrition, safe water, sanitation, clean air, housing, employment, safety at home, in the work place and on the roads. Social inequality deprives the poor of these basics. Is the medical and health profession interested in just medical care or also better health?

The WHO-UNICEF declaration in Alma Ata in 1978, on **Health for All** (HFA) by 2000 through the Primary Health Care (PHC) approach, used social justice as its basis and explicitly adopted intersectoral coordination as a strategy to address the need for access to basic determinants of health. The role and scope of the health profession and health sector was thus even then broadened beyond medical care. This was mandated and accepted by all WHO member countries, and followed up by resolutions, national health policies, plans and programmes. This was seen as an advance in improving the health of the poor. Very soon however this broad based approach was narrowed down, selectivised with vertical single disease programmes, and medicalised with a focus on diagnostics and drugs, not on people, communities and society.

In 2000, while WHO busied itself with Safe Blood as the theme of its WHO Day, on 7th April, impoverished peoples and civic society networks and movements in India pledged, through a national campaign, to continue to work with greater urgency towards Health for All, Now! This is part of a wider international peoples health campaign, leading to a Peoples Health Assembly in Dhaka in December 2000, which asserts that Peoples Health should be in Peoples Hands and reaffirms the role of the state in primary health care and public health (PHA, 2000). At the turn of the millennium we need to be analytical and remind ourselves of the reasons that prevented Health for All, through Primary Health Care, from becoming a reality.

STRATEGIC APPROACHES TO IMPROVED HEALTH FOR THE POOR

Promoting Indigenous Systems of Medicine and Healing Traditions

Poor people across the world have developed diverse traditions of healing and systems of medicine. Women are often the carriers of local health traditions and also carers of people during illness. Modern medicine with scientific arrogance has often

labelled traditional knowledge as non-knowledge, and healers as quacks and witches, causing disempowerment and loss of heritage. There is an urgent need for dialogue based on respect, to enable learning, restoration and promotion of these systems and traditions. This needs to be accompanied by safeguarding community and people's rights from the avariciousness of commercial interests and patent rights.

As part of its 5000 year old living civilisation, India has evolved several indigenous systems of medicine, such as *Ayurveda* (the science of life) *Siddha, Unani, and Yoga*, all with texts, which form part of the world's oldest written medical literature. A wealth of local, oral traditions exist, being passed on from generation to generation by folk healers. Similar knowledge bases and caring traditions exist world-wide. There is minimal budgetary, legal and institutional support for the growth and promotion of these systems. They are scarcely involved in health planning and programmes. Some have been pushed into subaltern states by the dominant modern biomedical paradigm. Recognition, legitimisation and strengthening of these traditions will enhance the contribution of people themselves to improved health and quality of life. Supported by the philosophical traditions they represent, indigenous systems are less compartmentalised, and deal differently with issues such as the meaning of life, quality of relationships, attitudes, and acceptance of death. In the quest for health we need to include multiple world views, multiple realities, multiple voices. For this we need to listen, to learn, and to allow a questioning of the hegemony of modern medicine.

Fostering Community Involvement

Community involvement, a cardinal principle of primary health care and of community health, has been fragmented by a combination of professional and commercial interests (the doctor-drug producer axis) operating through market forces. It has been declared idealistic, non-workable and immeasurable by experts, who are impatient and focussed on specifics.

The potential power of the community as healer, as being able to hold brokenness and restore wholeness, are human and higher dimensions beyond market and biomedical paradigms.

At another level, community involvement in micro-planning, decision making and in running health programmes have made possible more rapid, sustainable, health gains, at low cost. This is the experience of NGOs globally. Community participation in public sector programmes, through elected representatives and civil society groups, enhance implementation, including quality.

On a larger scale, social movements of the poor raise basic issues, which impact on health. These include movements regarding livelihoods, water, and environment. Socially conscious professionals and others have worked on campaigns for rational therapeutics, women's health, and workers' health, from which there is an emerging health movement.

However resistance by the medical profession to subject itself, and its technology, to social control, through local committees, consumer and patient groups, ethical committees and elected local bodies, hampers outreach, development and access to the poor, and is one of the barriers between people and the health services.

Bridging Implementation Gaps

All aspects of health policy in some countries, including problem identification, policy content, programme planning and implementation, are influenced by dominant

interests, in ways such that the needs and interests of the powerless and poor come last (Narayan, 1998). This is evident in the poor implementation of tuberculosis programmes with continuing high mortality and poor treatment outcomes, despite effective, low cost treatment.

High rates of child undernutrition and anaemia; large proportion of people still lacking access to safe water and sanitation; high maternal, infant and child mortality; are all witness to implementation gaps in public policy.

Political economy factors are evident in the energetic promotion, on the other hand, of population programmes, euphemistically given new names, such as, family welfare, reproductive and child health, but still driven by demographic determinism. These factors are also evident in the disproportionate leverage in national policy planning that donor agencies expropriate, despite very small proportions of actual aid, or more recently even with loans.

Several scholars and agencies recognise the need to improve institutional mechanisms to strengthen implementation and reduce gaps. This includes the need for good governance, leadership at different levels, management, and most importantly strengthened capacities and humane attitudes and relationships, at the interface between patients, people and providers. Involvement of different stakeholders, especially women and NGOs, with systems of accountability and transparency, enhance implementation. There is a recognition however that the poor, preoccupied with survival tasks, are the least organised and articulate, with less bargaining and negotiating abilities. On the other hand, professionals, technocrats, bureaucrats and industry, form strong alliances. With access to upto date information, good communication and coordination mechanisms, the playing fields are very uneven. Thus implementation factors are complex, but need to be given priority and close attention, at all levels, particularly locally, if better health for the poor is to become a reality now (Narayan, 1998).

Addressing Political Processes and Power

At the turn of the millennium there is a need for explicit recognition that political structures and processes, and issues of power, help determine content, direction and implementation of health policies and programmes. Equally important is the recognition that the medical profession itself is a strong political player, very protective of group interests, well organised, working in alliance with governments, industry, and international agencies, and often unmindful of the real interests of the poor, despite public statements and individual acts of commitment. Professionals as a group violate the health rights of the citizens, particularly the poor, by non-implementation, non-action, apathy, non-availability, provision of poor quality care, corruption and rude behaviour (Narayan, 1998). Though occurring to different extents in different parts of the world, this factor needs recognition and redressal.

Preventing Distortions due to Privatisation

Another important issue, in the current neoliberal context, that hurts the interests of the poor, is the promotion of privatisation in all sectors, particularly in medical and health care, by powerful institutions such as the World Bank and allied bodies. Despite cautions by WHO, these institutions used loan conditions to further this agenda. Thus commercial high tech, secondary and tertiary care was introduced, opening up

markets for multinational consumer products, along with stagnation and reduction in real public sector health spending. This worsened pre-existing inequities in health.

Global policy prescriptions for contraction of public sector expenditure, derived in part from over-extended unsustainable health budgets in industrialised countries, following rising costs of medical care. Generalisations to countries with different contexts, where health budgets were far below WHO recommended norms, makes any contraction of health expenditure counter productive, leaving money for salaries but not for service or infrastructure maintenance. A public private mix is advocated with a larger role for the private sector, in the absence of evidence of significant or sustained private sector participation in health promotion, health prevention, rehabilitation or public health. There is also little evidence of greater cost effectiveness, efficiency or quality of care in the private medical sector, particularly in low-income countries, where regulatory mechanisms are least developed. These policy changes have diminished access to care, particularly for the poor, causing shifts to poorer quality care in the informal sector and in households by families, thereby adding to the workload and anxiety, particularly of women. The ethics of introducing major policy changes, without evidence or monitoring, need to be addressed.

There is widespread concern about the potential impact of the World Trade Organisation (WTO) agreements on access to health care (PHA 2000, Health Counts 2000). For instance, the TRIPS agreement (Trade Related Aspects of Intellectual Property Rights), through patents and higher drug prices, prevents access by the poor to the benefits of new science and technology developments in the pharmaceutical industry.

Responding to Indebtedness and Ill-health

In low income countries, in the absence of functioning public sector health services, a significant proportion of persons with chronic illness or acute emergencies get indebted while purchasing private medical care (Narayan, 1998). In India, medical expenditure comprises the second most important cause of rural indebtedness. Studies in China show that chronic ill health is a cause for persons and families being pushed below the poverty line. Public sector provision of medical care therefore has a poverty alleviating effect on households.

At a global level, NGOs, the Jubilee 2000 coalition, UNICEF and others have documented the adverse effects of international debt on the health of the poor. In 40 heavily indebted poor countries, life expectancy is 12 years lower than other developing countries and 27 years lower than industrialised countries (BMA, 2000). Debt repayments surpass health expenditures by 3-4 times in these countries. The per capita expenditure in health in these countries is less than £6, while it is more than £950 in the U.K. (ibid.).

With a total debt of $2000 billion (UNICEF, 1999) there is a net transfer of resources from poor to industrialised countries and a continuing of the process of impoverishment, which has a deep structural roots.

Besides indebtedness, conditions linked to Structural Adjustment Programmes result in increased unemployment, a shift to the informal sector where there is no social security, introduction of user charges, reduced access to care, downsizing of the public

sector in health, changed nutritional status and increased nutrition, insecurity with withdrawal of food subsides and currency devaluation. These changes have been documented in Africa, Eastern Europe, Latin America and Asia, with widening gaps between and within countries. Urgent action is required to address this issue.

CONCLUSION

Important issues concerning health of the poor and poverty and health linkages, have come to the global policy agenda, during the last few decades of the millennium. They reflect widespread concerns that we, the human race, have not done as much as we had hoped or expected. Valuable lessons have been learned, and insights gained, during the struggle or period of trying to reach Health for All by 2000. This knowledge gained has been both experiential and research based. The challenge before us is how we integrate this knowledge, including the negatives, into positive, affirmative action for equity in health. Equally important is how we go about the process, moving beyond biomedical and market paradigms, allowing ourselves to be led beyond barriers, especially by the agency of the impoverished. ■

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"Now we are having a very difficult life,

Experience from the Field in Tanzania

WHEN DISEASES RELATED TO POVERTY ARE CONCEIVED AS BEING BROUGHT ABOUT BY WITCHCRAFT

Mwajuma S. Masaiganah

we have no clothing, we have no food to eat, not even skin oil. You know, a woman is supposed to oil her skin! – (Sasa tunaishi maisha ya shida kweli, hatuna nguo, hatuna chakula, hata mafuta ya kupaka sina, mwanamke ni kupaka bwana!)" Mama Julia, Tanzania.

Background

This story is about Jared Subeti, a father of two who lives in a village called Engusero in Kiteto district, Arusha region, Tanzania. He and his wife make a living by doing casual labour and subsistence farming activities. "This year we harvested nothing, not even a tin of maize," says Mama Julia, Jared's wife. "We farmed last when the rains were about to go and so harvested nothing from the farm". This was said by Mama Julia when we visited their place to make a follow up on the developments that Jared might have made from being poor to having a better life, according to "our perception."

The first time we met Jared was in early 2000 on an assignment by Orgut Consulting Ab. to do a mini Participatory Poverty Assessment. During discussions with the villagers, Jared's household was identified as being the poorest of the poor in the village and so the group decided to visit him accompanied by the Village Secretary. Jared lived in a grass-thatched hut outside the village centre. He lived there with his pregnant wife and one female child called Julia.

First our going there pulled a lot of crowd to the house. Of course the notion was that how could a poor person like him be visited by people and apart from all with/in a car. We sat outside the hut on grass and the Village Secretary introduced us. We told him that we were looking at the well being of the people in the village and that we want to learn from them about their lives, livelihoods and coping strategies; and their relationships in their daily lives.

His route to poverty:

At first Jared did not want to talk to us, he was hostile but his wife was very calm and started talking and insisted that he should talk to the guests, may be it is God who has sent them there. So, finally Jared agreed to give his personal history as follows: -
"I came here in 1999 after fleeing form Dabalo village in Dodoma district because of the death of my two children, my sister and uncle who died due to witchcraft. I was born in a well off family. We lived a happy life then, my father had a herd of cattle amounting to sixty. Our poverty started when we moved from our village Hosteti to Izara village where all our cattle died. There we started to feel the suffering. As I was married we moved to Dabalo with my wife but when we lost our children, my sister and my uncle who we had followed there, I decided to flee from there to this place. When I came here I had nowhere to stay

but I was given that unfinished house by one villager here and assisted by the church Reverend to survive. Then I started casual labour and the money I get is only enough for food. We do not know what we eat next day."

Mama Julia also said that during that season, she was expecting to harvest, mud-plaster their three-roomed hut and have a better life. "Now we are having a very difficult life, we have no clothing, we have no food to eat, not even skin oil. You know, a woman is supposed to oil her skin! –(Sasa tunaishi maisha ya shida kweli, hatuna nguo, hatuna chakula, hata mafuta ya kupaka sina, mwanamke ni kupaka bwana!)"

When children die of malaria – It is witchcraft!

They explained to us that all their two children died of witchcraft, but all symptoms showed that the deaths occurred due to either malaria or meningitis. And because of their belief in witchcraft and not having means to send the children to hospital, they then lost the children.

Malaria kills over a million people world-wide each year, of which 75% of them are children from Africa.

Relationships and our perceptions - development workers perceptions

Relationships

Jared was wearing a piece of kanga torn in the middle and the ends sawn together. He could not even get out of the home because he has nothing to wear for fear of being laughed at. When asked if he attends any village meetings, he said, "Where can you go like this? They will laugh at you. After all who will come to tell you that there is a meeting in the village? They know that you are poor and you cannot contribute to development, so you are left out. Nobody cares for you. Even though, I have no guts to go out the way I am."

Jared's relationship with the village and village government

In the village there are development activities, which affect all villagers and are all supposed to take part. During our discussions we wanted to know whether they have been involved in any village meetings or in any development activities and the response was: - "We have never been in any meeting in the village because nobody tells us that there is a meeting. Poor people like us are never notified because they think we have nothing to contribute, not even ideas. Another problem is that even if we know that there is going to be a meeting. Let us say I talk to someone and he tells me so, I cannot go because of my poverty situation. I have no proper clothing. I cannot attend a meeting putting on clothes like this. It is shame, they will laugh at me." The above statement shows clearly that the poor and the disadvantaged people are not involved in any social development activity and they thus become socially secluded and so lack social protection.

Our perceptions as a means of Jared getting out of poverty

The team went back and discussed the situation, which we saw there and everybody was real struck by the situation. We looked for ways of helping them get out of poverty. Every member of the team decided to contribute something the next day, as it was a market day to the family and made arrangements with the Village Secretary to take us there in the afternoon. We met at around two after having our meeting in the office at the market place. We all bought something for the family, shirts and trousers for Jared, dresses for Mama Julia and for Julia, sandals, bed sheet, soap, flour, rice,

cooking oil, haplochromis (type of small fish) and of course skin oil as she had earlier said "...mwanamke ni kupaka bwana." We perceived that this will help them to have time to do casual labour and make a saving and also have the time to do farming in their own farm. When we went to send these things, they could not imagine how that could happen to someone so poor like them. The woman exclaimed and said, "...When you came here yesterday my husband thought you came to mock us. But look, all this is God's will. From today on, I will attend to the church."

Follow-up – Life in crisis

After seeing all this, I developed a personal interest of wanting to see how this will develop in the future and wanted to make a follow-up on Jared's life. More that a year later I decided to visit Jared. Gosh! I did not believe what I saw. No one of us believed. The condition had gone from worse to the worst. That was absolute poverty. What we had seen before was nothing. The hut was falling, two rooms were all down and the last room remaining was to the point of falling over them. The wind was blowing from the eastern side of the room, which was leaning to the west straight into the hut. One cannot imagine how they managed to sleep there in such openness.

Mama Julia had given birth to another baby boy called Robert. Robert was asleep when we arrived and was rapped in a piece of cloth and packed in a corner of the hut that was still standing on a piece of goatskin. When she delivered she got support from the Reverend's wife who has now shifted to another village. They had nothing left except a bucket, a pot and a cooking pan placed near the fireplace. Jared was not home by then and the wife said that he was away in the farm building a new hut in the farm that he has inherited from her sister and they were going to move there. She said that their hut is in that condition now because the husband had said there was no need to repair the hut while they were going to move to the shamba (farm) in Matembo village. Mama Julia said that they did not harvest anything in that season as they had planted their crop late so they got nothing.

Julia, who used to be a happy girl, looked sad and her eyes seemed to be infected probably by trachoma, as she could not see properly. If she gets no medical help, she may possibly become blind.

Conclusion

Poverty is a cause of may deaths especially in Africa and other developing countries. People live in what is called abject poverty not knowing how to get out of it or with no hope of getting out of it. The way Jared lives in a dangerous and temporary hut gives us a picture of what poverty means.

Our perceptions as outsiders, usually is that giving out something will get someone out of a problem, yet Jared's story shows it differently. Though contributions or grants are sometimes a must, but the counselling and training before donating is very vital. Trying to make a third follow-up of Jared's life proved futile, as he had moved to a remote village where nobody knew how to get him.

There is need for governments and other development institutions like WHO, UNICEF etc. to work together towards proper implementation of pro-poor policies those that they design to real become pro-poor. They should see to it that no child dies for example because of malaria, which is a preventable and at the same time curable disease, as a result of the family being poor. Health facilities and services should be

accessible and affordable. This is only possible if the health systems are well financed and taken care of. The strategy of PHC is to promote health through reduction of inequalities and social exclusion as the one that affected Jared's family.

Pro-poor processes must involve poor people themselves to determine what they want. Our misconception of Jared's problem is a good example in this, guiding us to change course where there is need of full involvement and participation of people in their own development endeavours. ■

"The perfumed flowers are our brothers;

Gene Research – Myths and Realities

Daniela Conti

the deer, the horse, the great eagle are our brothers; the rocky coasts, the green of the grass, the warmth of the pony and the man, all belong to the same family.

The white man. treats his mother, the Earth, and his brother, the sky, as if these are only things to be bought, taken and sold, as one does with goats and precious stones. His greed would swallow all the earth till only desert will be left for him. Our traditions are different from yours'.

The sight of your cities pains the eyes of the red man. But perhaps it is because the red man is a savage and does not understand. There is no quiet place in the white man's cities. No place to hear the leaves of spring or the rustle of insect wings. But perhaps because I am a savage and do not understand, the clatter only seems to insult the ears. What joy is there in living, if man cannot hear the sweet sound of the wind or the sound of perfumed pine leaves moving in the wind? The air is precious for the red man, because all things breathe the same air. It seems that the white man does not care about the air that he respires.

But if we have to sell you our lands, I will pose one condition: the white man will need to respect as brothers all the animals that live on those lands. I am savage but I know no other way of living.

I have seen thousands of rotting buffaloes on the prairie left by the white man who shot them from a passing train. I am a savage and do not understand how the smoking "iron horse" can be more important than the buffaloes, when we kill them only for survival. What is man without the beasts? If all beasts were gone, men would die from great loneliness of spirit, for whatever happens to the beast happens also to the man.

All the things are inter-connected. We know at least this: the earth does not belong to the man, but the man belongs to the earth. We know this. All things are inter-connected, as members of a family are inter-connected by the same blood. Man did not weave the web of life, he is merely a strand in it. Whatever he does to the web, he does to himself. The whites, too, shall pass perhaps sooner than other tribes. Continue to contaminate your bed, and you will one night suffocate in your own waste.

Where is the thicket? Gone. Where is the eagle? Gone. And what is it to say goodbye to the swift pony and the hunt? The end of living and the beginning of survival."

I wanted to start with this long citation from the Amerindian chief Seattle because I think that in many of us these words, written about 150 years ago, **vibrate** profoundly and evocate a kind of nostalgia for a world that was, which was perhaps known by our elders, but which is dramatically disappearing before our eyes.

Cooperation and Co-Evolution in Life-

systems: The western culture often ignores an essential element in the history of evolution of life on the planet, that is cooperation between the different life-forms, in certain cases developed to the extreme level of symbiosis, where two organisms become inseparable and can not live without the other. This ancestral origin is the reality of every cell composing our bodies. Another fundamental element, systematically ignored is that of co-evolution, where every species is as it is because of interaction with other organisms, things and events. Thus every species and every individual owes its existence to its history. Thus, only in a distorted and reductive way of thinking, a living organism can be de-historicised and de-contextualised, as if it's identity is independent of network of relationships, which made it what it is and, which modify it constantly.

Evolution is co-evolution, in human sphere, as well as for the general relation between organisms and environment. A plant that grows today does so in an oxygen-rich environment created by its ancestors, who had invented a new kind of photosynthesis, an efficient process that generated oxygen as a by-product of energy-metabolism. Over a period of millions of years, this process helped in changing from a methane and sulphur dioxide rich environment to the oxygen rich environment. However, oxygen was toxic for most forms of life existing on earth at that time and this change initiated the first big extinction of life forms on the earth. Those life forms, which tolerated oxygen, or those which became capable of using oxygen through respiration, inherited the Earth, and from those early life forms descended all the life forms that we know today, including those that have become extinct long ago. Environment modifies and selects the life forms and life forms modify the environment – this is an eternal interplay. This is why the quality of reciprocal relationships between all organisms is important for the continuation of life.

However the dominant scientific vision at present seems to look at different forms of life in an isolated manner, without considering the complex system of reciprocal influences and the evolutionary pathways connecting them. In biology, this reductionist vision isolates organisms from the context of their relations and from the flux of time, considering them only in terms of their molecules **of** DNA, as if this is the only key of the life. Starting from such a vision of life, it is possible to change the so called "identity" of the organisms in a mechanical manner, pretending that such an operation will not interfere with overall functioning of that organism. However, there cannot be a plant or an animal, even if you reduce them to their minimum terms, that is to their DNAs, on which you can operate ignoring the relations between the organism and the external environment, between its different cells and between the different components of the same cell. This reductionist model of biology reflects a simplistic view of the world, as shown clearly by genetically modified organisms (GMOs) and clonation experiments.

The soybean modified by the insertion of a bacterial gene for making it resistant to a specific herbicide, is no longer the same soybean. Monsanto, which produced and patented this soybean (and herbicide), has itself admitted that the DNA of the transferred gene contains new sequences that were not there originally and are a result of an interaction between the inserted gene and the plant system. Let's consider Dolly, the first cloned sheep: she is already old and full of diseases as the adult from which it had been cloned. Why? Because even

the time, the memories – that is, the history - are inside the living matter, they modify it and leave their signs also in the DNA. For a living organism, functioning well means being in a flux of continuous transformation, that has a temporal direction made of development → maturity → decadence → death cycle, a complex mix of phenomena that science still does not understand so well.

Theoretical Fundamentals of Genetic Science: What are the basic theoretical premises of genetic science? Barry Commoner, a great scientist and father of modern ecology writes[1]:

> *"The experimental data, shorn of dogmatic theories, points to the irreducibility of the living cell, the inherent complexity of which suggests that any artificially altered genetic system, given the magnitude of our ignorance, must sooner or later give rise to unintended, potentially disastrous, consequences. We must be willing to recognise how little we truly understand about the secrets of the cell, the fundamental unit of life. […] ..money has distorted the scientific process as a once purely academic pursuit has been commercialised to an astonishing degree by the researchers themselves. Biology has become a glittering target for venture capital; each new discovery brings new patents, new partnerships, new corporate affiliations. But as the growing opposition to transgenic crops clearly shows, there is persistent public concern not only with the safety of genetically engineered foods but also with the inherent dangers in arbitrarily overriding patterns of inheritance that are embedded in the natural world, through long evolutionary experience. Too often those concerns have been derided by industry scientists as the "irrational" fears of an uneducated public. The irony, of course, is that the biotechnology industry is based on science that is forty years old and conveniently devoid of more recent results, which show that there are strong reasons to fear the potential consequences of transferring a DNA gene between species. What the public fears is not the experimental science but the fundamentally irrational decision to let it out of the laboratory into the real world before we truly understand it."*

These words summarise all the problematic and risky aspects of the transgenesis and clonation, two main areas followed by dominant apparatus of genetics. On one hand emerges the increasingly intense "colonisation" of the research, even of the public sector, by private interests, often of big transnational groups, which move exclusively for immediate profits and for monopoly on genetic resources and knowledge. This also means, difficulty of finding resources for those researchers, who wish to follow alternative pathways of research, and are thus marginalised from the academic environment. On the other hand, Commoner underlines the cultural deviation of the scientific apparatus that seems reluctant to ask questions about and significantly modify the theories already proved "incorrect" by the new experimental data, as should be usual in science, because the old theories are necessary to maintain and safeguard the economic interests and

[1] Commoner B, Unravelling the DNA Myth – The spurious foundation of genetic engineering, Harper's Magazine, February 2002

interests of scientific apparatus.

Let us now look at the basic theories, which justify the modification of living organisms through genetic engineering. The basic idea is linked to the "central dogma", called so by Francis Crick, discoverer of the double helix of the DNA, along with James Watson. Commoner explains this central dogma in the words of Ralph Hardy: "...Ralph W.F. Hardy, president of the National Agricultural Biotechnology Council and formerly director of life sciences at DuPont, a major producer of genetically engineered seeds. In 1999, in Senate testimony, he succinctly described the industry's guiding theory this way: "DNA (top management molecules) directs RNA formation (middle management molecules), which directs protein formation (worker molecules)."

Thus the final result of a gene transfer becomes as predictable as a corporate organisation: the workers, that means proteins, are going to do exactly what their bosses (DNA) will tell them to do. A gene is seen as the only determinant of a protein-production process, where DNA (through specific RNAs) commands a specific protein chain and there is a constant, unidirectional command-line between the DNA and the protein. Since proteins are responsible for every function and structure present in the body, together the genes of an organism account for all its hereditary characteristics. At the same time, this concept of DNA as the unique determinant justifies the transgenesis: a certain gene from whatever species can be taken, transferred in whatever species, and it will produce the same protein and nothing else.

Thus gene transfer does not need to face the barriers, which need to be respected by traditional genetics, bound by natural mechanisms of reproduction and crossbreeding. For this reason and because it uses specific instruments like artificial vectors for gene transfer, the genetic engineering can not be compared with traditional genetics and represents a new and unprecedented technology of intervention on nature. The argument of "gene as the unique determinant of a protein" is also used to justify the patenting of genes – if a gene controls one particular function, and thus has a determined "utility", and if one can isolate it and make it do that function in an organism, in which that gene does not exist, then a patentable innovation has been created. (In reality, this is a gross over-simplification of the real situation since the patenting of gene is an extremely confused subject and there are many patents for an entire species as it exists in nature, by-passing thus the vague concept of "utility".)

But is the central dogma true? Is DNA really at the top of the pyramidal hierarchy representing the molecular fundamentals of life? Well, many discoveries of the last two decades suggest otherwise. One of the important results coming from the **Human Genome Project**, that wanted to identify all the genes determining our characteristics, is that there are insufficient number of genes in human DNA (only 30-40 thousand) to justify one-to-one correspondence between the genes and the hundreds of thousand**s** of proteins which make our bodies. How can we explain the disproportion between the number of genes and the number of proteins? This brings to one of most fascinating discoveries, confirmed also by Human Genome Project, alternative splicing of genes. Without entering in to all the details, to explain this let me start from our knowledge that from the "working copy" of a gene (a RNA), parts relating to entire genetic sequences are cut,

while the remaining parts are united to make messenger RNA, which comes out of cell nucleus and is translated in to a protein in the cell cytoplasm. Alternative splicing complicates this, because the pieces to be cut and made in to messenger RNA are not fixed sequences, but these change according to the needs of the cells. Thus starting from the same gene, we can come to 2, 5, 6 or even more different proteins (for example, a gene in the fruit-fly can produce 38,016 different protein variants). What changes is not the gene sequence in the DNA, but it's the process on the "working copy" of the gene. How is this process regulated? We don't know all the details but this extraordinary and unsuspected flexibility of DNA is influenced by the interaction with the cell environment through a complex network of signals (through contacts and relationships).

Challenges to fundamentals of genetic-theory: There are other phenomena discovered during the last 20 years, which contradict the fundamental postulates of genetic-theory. One of these is the still mysterious editing of RNA, which changes the "working copy" of the gene by adding instructions (bases), which influence the final protein. These information do not come from the original gene in the DNA **but** come from somewhere else. Another example is that of development of embryo, when cells sharing the same DNA codes develop in to very different kind of cells. Thus apart from the "programme" written in the double helix of DNA, is there some kind of "spatial project" of the body? How is it codified? We do not know. Special proteins called "chaperones" are needed to act on newly made proteins in chain-form, to make them take a three-dimensional form necessary for their activity. What gives information to chaperon**es** to give correct forms to newly made proteins? Another well-known example comes from the mad-cow disease or BSE, caused by prions. These prions seem to be made only of proteins, without any nucleic acids (DNA and RNA), yet they are infective, simply through contact. All these examples, contradict the basic fundamentals of genetic-theory and some of these seem to suggest that proteins are not simple executors of instructions, but have their own autonomy of action.

Implications of these challenges to fundamentals of genetic-theory: The research of the last two decades suggests that DNA is a very flexible system and fundamental unit of life the cell, considered as an integrated system, result of thousands of years of co-evolution of all its components, including proteins and nucleic acids. DNA cannot function alone and is not the head of any hierarchical pyramid. Of course, it has a key role; in its molecule there is the registration of the evolutionary history of the species - it is an essential archive, historical and continually changing and becoming – and the organism takes information from this archive for its development and for its daily life. However, it is not the only determinant. The organism, through its cells' functions, makes decisions all the time about the genes to be activated and those to be inactivated, about the kinds of proteins to be produced and those that are not needed, in a process of constant interaction with the environment. "Cellular democracy" is the name given to this process by the scientist Mae-Wan Ho, creating a new and very powerful image of biological complexity.

These results have enormous implications for the biological theories and have created some disturbance and anxiety among those united under "Intellectual Property Rights Ltd" bandwagon, formed by big

corporations as well as by medium and small companies involved in genome research and gene sequencing, hunting for genes to be patented.

Patents and Genes: Just to get an idea about the enormous interest of biotech industry in gene patents, I can refer to an interview made by John Doll, director for Biotechnologies at US Patent and Trademark office (USPTO) to Scientific American magazine in 2001. He said, "The only number we have about patented gene can be a hypothetical estimate. Since 1980, our office has released more than 20,000 patents on genes and related molecules (human as well as from other organisms). In addition, we know that there are about 25,000 pending requests for patents linked to genes and related molecules."

Given the fact that information about patented gene sequences is fragmented and covered with secrecy, we do not know the number of human genes already patented! And, in the middle of enthusiasm came the cold shower of the results of the Human Genome Project. When it was announced that the human genes were only 30-40 thousand, the financial trading indices for biotech companies dealing with genetics went down. With the genes and sequences already patented or ready to be patented, these companies are going to have a big amount of capital, excluding the late-arrivers. At the same time, there were already attempts to negate the results of the two teams involved in human genome research, insisting that in reality the number of human genes is much more, 60, 90 or 120 thousand. The biotech industry, built on the foundations of patents for exploiting the monopoly over "genes of single diseases" or "genes of behaviour", feels shaken to its core by the discovery that single genes do not control single proteins, but that DNA lives and functions as a complex system, co-evolving with proteins. That is why the confusion of the "Intellectual property rights Ltd" that if a gene is not the only determinant of a protein, what will be the value and credibility of their patent on that gene? Who is going to resolve the long and tortuous legal conflicts between commercial exploitation of two different proteins deriving from the same gene?

Calming the panic of "Intellectual Property Rights Ltd.: The panic about the results of Human Genome Project has been calmed through the reductionist logic. There are still more patents to be awarded. Now the object of hunting is "Proteoma", all the proteins taken together. Mr. Doll of the USPTO has found a solution, "Proteins deriving from different sequences of the same gene can become distinct 'inventions' and thus can be object of separate patents".

Considering the challenge posed to our sense of humanity and to our intellect by the complex web of life, such discussions and solutions for buying, selling and controlling our life system, may seem petty and selfish. This is inevitable product of that all pervading thinking, where power is the only goal and in the name of power, wars, genocides and disasters of different kinds are carried out.

The Challenge to us: It is important to bring a profound change to our way of dealing with issues. We have to make a distinction between power and strength, aware that power can only generate accumulation and necessarily leads to new conflicts. The strength is, on the other hand, the unending source of complexity that continuously generates life at a higher level of emancipation. Cooperate is the new verb that we have to put in to use. We are part of a complex system that lives in an even

bigger and more complex system, as the Amerindian head-chief Seattle had spoken 150 years ago. Wilhelm Reich wrote in all his books that love, work and knowledge are the source of our life and these should govern our lives. Instead, we see continuous impoverishment of these simple yet profound concepts. Personally I believe that we need not be courageous but we just need to remove our fears and to liberate our creative force. Love cannot be bought or sold, work cannot be exploitation, knowledge is the wisdom of being what we are: living beings in relationship with other living beings, "forced" to cooperate with others.

This is the future that I would like to wish for all of us. ■

ANNEX

PEOPLE'S HEALTH ASSEMBLY AND PEOPLE'S CHARTER OF HEALTH

In 1978, at the Alma-Ata Conference, ministers from 134 members countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of Third world populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterised by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalisation which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata, has significantly aggravated the global health crisis. Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of Health for All to its rightful place on the development agenda. Genuine, people-centred initiatives must therefore be strengthened in order to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organisations and civil society movements, NGOs and women's groups decided to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organised the "People's Health Assembly" which took place from 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthaya Kendra or GK (People's Health Centre).

1453 participants from 92 countries came to the Assembly which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The Plenary Sessions at the Assembly covered five main themes: Health, Life and Well-Being; Inequality, Poverty and Health; Health Care and Health Services; Environment and Survival; and The Ways Forward. People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organisation. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five days event gave participants the space to express themselves in their own idiom. They put forward the failures of their respective governments and international organisations and decided to fight together so that health and equitable development

become top priorities in the policy makers agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The Charter from now on will be the common tool of a world-wide citizen's movement committed to make the Alma-Ata dream a reality. We encourage and invite everyone who shares our concerns and aims to join us by endorsing the Charter.

PEOPLE'S HEALTH CHARTER

Preamble

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

Vision

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

The Health Crisis

> *"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."*
> *(A voice from Central America)*

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to

compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

Principles of the People's Charter for Health

The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.

The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.

Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.

The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.

Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A Call For Action: Health As A Human Right

To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors. The demands presented below provide a basis for action. Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.
Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their

resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- ✓ Demand radical transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In particular, such transformation must include intellectual property regimens such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- ✓ Demand the cancellation of Third World debt.
- ✓ Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- ✓ Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- ✓ Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- ✓ Demand that national governments act to protect public health rights in intellectual property laws.
- ✓ Demand the control and taxation of speculative international capital flows.
- ✓ Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- ✓ Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social And Political Challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious

choice, to education and to freedom from violence.

- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
- Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose biopiracy of traditional and indigenous knowledge and resources.
- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular

audits that measure environmental degradation and the health status of the population.

War, violence and conflict

War, violence and conflict devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of military occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.

A People-Centered Health Sector

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drug policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organisation (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.

- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

People's Participation For A Healthy World

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly And The Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a *People's Charter for Health*.

The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the

Assembly meeting in Savar, Bangladesh, in December 2000.

The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health movement can gather and other networks and coalitions can be formed.

Amendment

After the endorsement of the PCH on December 8, 2000 it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended. ■

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